

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

UNIVERSITY OF CAPE TOWN
DEPARTMENT OF PSYCHOLOGY

**PATHWAYS TO INHUMANE CARE:
MEDICAL CULTURE IN A SOUTH AFRICAN EMERGENCY
UNIT.**

Thesis submitted to the Faculty of Humanities, University of Cape Town, for the degree of
Doctor of Philosophy.

by

SARAH SHELMERDINE
(SHLSAR002)

Supervisors: Prof. Sally Swartz and Prof. Donald Foster

May 2011

ACKNOWLEDGEMENTS

I would like to acknowledge the following people for their contributions to this thesis:

First and foremost, my supervisors, Sally Swartz and Don Foster, provided continual support and encouragement as well as sound and extensive guidance throughout the process of writing this thesis. Sally provided invaluable input into the conceptualisation of the project and, in particular, helped me to find the confidence in my own ideas that enabled me to pursue them. She further got me through the final stages with her reliable academic support and general encouragement. Without their contributions, this thesis would not have assumed the form that it did.

I would like also to thank my fellow PhD-sufferers, Adelene Africa, Sia Maw and Heike Schmidt, for their support in finding the courage to continue writing when one more word seemed an impossible feat. Their company in my frequent misery was an invaluable resource. I am very grateful too to Barbara Lewis who reminded me of why I began the process of a doctorate and why I should continue each time I reached the conclusion that I should not. My family offered practical assistance in the form, for example, of ferrying my daughter to and from school and a wide variety of other destinations, an activity that would have taken hours off each day and added years to completion of the project. And my daughter, Rose, made innumerable sacrifices in the interests of allowing me to work for no pay. Without her patience and understanding, life would have been Hell for everyone. In addition, I would like to thank my father for his infuriatingly meticulous editing and Gerard van Rensburg for his willingness to undertake those tasks too gruelling for me to endure.

Lastly, my thanks and gratitude is extended to all those who participated in this research, in particular the doctors and patients represented in this study. Their contributions represent the substance of this thesis.

ABSTRACT

While a comprehensive set of laws and ethical guidelines legally protects patients and promotes their access to good quality health care, inhumane and abusive medical practices have, nevertheless, been documented internationally. A large and varied body of work documents multiple aspects of medical culture. Many of the features described in this work have potential implications for the provision of inhumane care. That body of work discussing abusive practices and the violation of patients' rights in health care settings, however, remains small. Even fewer authors attempt explicitly to link the features of medical culture with the quality of medical practice in these terms. Thus, research that attempts to provide explanations for inhumane and abusive practices is sparse. This thesis begins by reviewing a broad range of literature discussing the context of medical practice, and highlights the implications of these discussions for an explanation of inhumane care. It then presents a study of abusive practices in a particular medical setting, namely that of a South African emergency unit. Using an eclectic mix of methods including participant observation, interviews and audio recordings of interactions between doctors and between doctors and patients, this study attempts to provide insight into the ways in which the discursive context in this particular unit mirrors characteristics identified by past research as common throughout medical culture more generally. It further attempts to show how some of these characteristics, as animated in the local context of this particular unit, in turn allow for the routine occurrence of practices that in other contexts might be unthinkable. This thesis argues that two broad narratives, identified in previous research and brought to life by the individual doctors in this unit, namely that of science and that of masculinity, dominate the unit's discursive context, rendering doctors all-powerful, superior and unquestionable; and offering the opportunity for aggressive domination. Within this context, doctors and patients are construed as binary opposites, establishing coherent groups of 'us' and 'them' and characterising doctors and patients as different from, and indeed in conflict with, one another. In combination with the construction of doctors as all-powerful within a situation in which failures are inevitable, as doctors attempt to cure a massive overload of patients with very limited resources at their disposal, doctors are susceptible to self-doubt and to feelings of failure and guilt. Invited to draw on a repertoire of defensive discursive strategies for warding off these feelings, made available within the broader medical culture, doctors frequently resort to blaming their patients, generating anger towards them and a paradoxical sense of their own victimisation.

The thesis shows how this process can lead, on occasion, to aggressive attempts by doctors to protect themselves from their patients and to re-establish their own threatened power.

Within a context construed in these terms, and inhabited by actors with the above characteristics, a range of actions on the part of both doctors and patients, that might otherwise be deemed unacceptable, become permissible and even likely, leading, in some cases, to provision of inhumane care and the violation of patients' dignity and rights.

University of Cape Town

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	I
ABSTRACT	II
TABLE OF CONTENTS.....	IV
CHAPTER ONE: INTRODUCTION	1
LEGISLATION AND PRACTICE: VIOLATIONS OF PATIENTS' RIGHTS IN SOUTH AFRICAN HOSPITALS.....	1
VIOLATIONS IN MEDICAL PRACTICE: THE RESEARCH	3
WHAT IS GOING ON?	4
THE CONTRIBUTION OF THIS THESIS	7
CHAPTER TWO: THE CULTURAL CONTEXT OF MEDICAL PRACTICE	9
MEDICAL CULTURE	10
<i>The relationship between medicine and broader society</i>	14
<i>The narrative of science</i>	18
Objectification	21
<i>Medical culture and religion</i>	29
<i>Certainty vs. uncertainty</i>	30
Uncertainty and authoritarianism	31
Self-regulation	33
Silence	34
<i>Masculinity in medical culture</i>	36
The military metaphor.....	37
The importance of action	38
SUMMARY	39
CHAPTER THREE: CULTURE AND IDENTITY	40
APPROACHES TO THE DISCUSSION OF IDENTITY	40
DOCTORS AS BIOSCIENTISTS.....	42
GROUP IDENTITY	42
<i>The defensive nature of collegiality</i>	43
<i>Collegiality and accountability</i>	44
'US AND THEM'	45
<i>Labelling patients</i>	47
MEDICAL CULTURE, IDENTITY, SELF-DOUBT AND DEFENCES	48
SUMMARY	52
CHAPTER FOUR: POWER IN MEDICAL PRACTICE	54
THE INSTITUTIONAL POWER OF MEDICINE	55
<i>Theoretical approaches to institutional power</i>	55
<i>Key elements of the medical profession's institutional power</i>	57
Medical knowledge	58
Autonomy.....	60
INTERPERSONAL DIMENSIONS OF MEDICAL POWER	62
<i>Approaches to the operation of power at the interpersonal level</i>	62
Power, society and the individual	63
Power as an interactional accomplishment	64
The conversation analytic approach	65
<i>Agency</i>	69
Knowledge and agency.....	70
Agency and blame	74
Patients' passivity.....	75
Patients' resistance	77
Doctors' responses to patients' resistance	80
SUMMARY	80

CHAPTER FIVE: PARTICULAR CONTEXTS AND INDIVIDUAL PARTICIPANTS	82
MEDICAL CULTURE AND THE INDIVIDUAL DOCTOR	82
<i>The individual doctor's emotional response</i>	83
THE IMPORTANCE OF PARTICULAR CONTEXTS	84
<i>The animation of discourse in particular settings</i>	85
THE SOUTH AFRICAN CONTEXT	87
<i>Medical culture, identity and power in the South African literature</i>	88
<i>The role of the medical profession in Apartheid</i>	89
<i>The South African public sector health system</i>	91
<i>Abuse in South African hospitals</i>	91
Explanations for abuse in the South African context	93
SUMMARY	96
CHAPTER SIX: METHODOLOGY.....	98
THE THEORETICAL FRAMEWORK	98
<i>The discursive movement in psychology</i>	99
Bakhtin's philosophy of language.....	99
The return of the unconscious	101
TRANSLATING THEORY INTO PRACTICE	101
<i>Ethnography</i>	101
Exploration of meaning in dialogical contexts.....	102
Meaning and action.....	103
<i>Narrative</i>	104
THE STORY OF THE STUDY.....	106
<i>The project's inception</i>	106
<i>Research questions</i>	108
<i>The setting</i>	109
The emergency unit.....	110
<i>The participants</i>	112
<i>Ethnographic methods</i>	114
Participant observation	114
The research relationships	116
Field notes	119
Audio-recording interaction	119
A reflexive experiential perspective	120
<i>The interviews</i>	120
<i>Analysis</i>	123
Transcription	123
Analysing talk as narrative.....	124
<i>Ethical considerations</i>	131
Consent	131
Confidentiality	134
Sensitive research	135
The project's aims	136
CHAPTER SEVEN: PILLARS OF MEDICAL POWER: GODS, SCIENTISTS, AND MEN IN THE EMERGENCY ROOM	137
GODS IN WHITE.....	137
NARRATIVE PILLARS OF MEDICAL POWER	139
<i>The narrative of science</i>	140
Knowledge and superiority	141
The supremacy of scientific practice	144
<i>Narratives of masculinity</i>	148
Masculinity and danger	150
Danger, action and violence	153
<i>Science, masculinity and care</i>	157
The importance of action with impact	157
Power and emotion.....	160

Power, vulnerability and humour	163
Humour and malice	164
DEFENCES	166
<i>Death in the doctors' narratives</i>	166
<i>Powerless gods</i>	171
INFINITE ALTERNATIVES.....	172
A MULTIPLICITY OF OTHER FACTORS	173
SUMMARY	174
CHAPTER EIGHT: A MUTUALLY ANTAGONISTIC SYMBIOSIS: THE RELATIVE NATURE OF DOCTORS' AND PATIENTS' IDENTITIES	176
US AND THEM.....	176
<i>The firm bounds of collegiality</i>	177
<i>Us vs. them</i>	180
DOCTORS, PATIENTS AND PERSONHOOD	182
<i>Patienthood and subjectivity</i>	182
<i>The subjective experience of objects</i>	184
<i>Subjectivity and agency</i>	190
The capacity of objects for action	190
Patients' resistance	196
The power of sole subjects.....	199
THE NARRATIVE POSSIBILITIES FOR SUBJECTS AND OBJECTS.....	201
<i>Personhood and communication</i>	201
Between us, about them	201
Speaking to objects	206
The mutuality of one-sided conversations	207
<i>Personhood and empathy</i>	208
<i>Collective identity and responsibility</i>	211
THE COUNTER DISCOURSE	215
SUMMARY	219
CHAPTER NINE: AGENCY, RESPONSIBILITY AND SELF-DOUBT IN THE DOCTORS' NARRATIVES OF POWER ... 221	
AGENCY AND RESPONSIBILITY.....	222
<i>Responsibility, reality and the possibility for positive self-evaluation</i>	223
<i>Guilty or not guilty?</i>	225
<i>Guilt and blame</i>	228
Blameworthy patients	232
<i>Subjects and objects, victims and perpetrators</i>	237
<i>Caring for perpetrators</i>	241
Blame, hostility and quality of care	242
Reassertions of power and the potential for abuse	244
Blame and accountability	246
<i>The cycle of guilt, blame and power</i>	247
SUMMARY	248
CHAPTER TEN: SUMMARY AND CONCLUSION..... 250	
SUMMARY OF FINDINGS.....	251
<i>The literature</i>	251
<i>The empirical findings</i>	255
SOME CONCLUDING REMARKS.....	262
<i>Some possibilities for effecting change</i>	264
LIMITATIONS	265
FURTHER RESEARCH	266
REFERENCES..... 268	

CHAPTER ONE

INTRODUCTION

Legislation and practice: Violations of patients' rights in South African hospitals

South Africa is often said to have some of the best legislation in the world, in that it is designed to protect its citizens, including patients, from ill-treatment of every kind. With respect to the legislation relevant to provision of humane health care, our legislation is comprehensive, protecting patients from violations of their dignity, freedom, physical and psychological integrity and from being subject to medical procedures to which they have not consented. For example, the South African Constitution enshrines the dignity of every human being, stating that, "everyone has inherent dignity and the right to have their dignity respected and protected" (South Africa, 1996). The National Health Act protects the right of patients to participate in any decisions that affect their personal health and treatment, and stipulates that for a doctor to perform any health service he must receive the patient's informed consent (South Africa, 2003). While not legally binding, the Patients' Rights Charter (South Africa, Department of Health, 2003) sets guidelines that health care professionals are expected to follow and reinforces these rights, stating that "everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects any one of these elements." In addition, the National Health Act renders "All information concerning a (health service) user, including information relating to his or her health status, treatment or stay in a health establishment, confidential."

The South African Constitution (South Africa, 1996) and National Health Act (South Africa, 2003) also states that no one may be refused emergency medical treatment, a right that is again reinforced in the Patients' Rights Charter (South Africa, Department of Health, 2003), which adds that this treatment should be delivered in a "timely" fashion. The Constitution enshrines the right to freedom and security of the person, stating that all persons have the right "not to be deprived of freedom arbitrarily or without just cause," "to be free from all forms of violence," "not to be treated or punished in a cruel, inhumane or degrading way," and to bodily and psychological integrity. It further states that "No person may unfairly

discriminate directly or indirectly against anyone.” In addition, the Patients’ Rights Charter requires that health professionals display “a positive disposition” that “demonstrates courtesy, human dignity, patience, empathy and tolerance.”

While this comprehensive set of laws and ethical guidelines legally protects patients from exposure to inhumane care and supposedly ensures their access to good quality services, the following excerpts from South African newspapers indicate a discrepancy between theory and practice. On May 28 2009 a South African newspaper quoted the Democratic Alliance as damning “The death of a 16-year-old boy from suspected meningitis at the Chris Hani Baragwanath Hospital (a leading academic hospital)...(as) ‘shocking’ and ‘inexcusable,’” reporting that the boy had been “misdiagnosed four times and left...untreated for three days,” eventually dying after a doctor at the hospital “allegedly told (the boy’s) mother that (he) was on drugs.” (“DA: Boy's death 'inexcusable’”, 2009, May 28). Reporting on the death of one of six babies from klebsiella at Prince Mshiyeni Hospital in Durban, the same newspaper alleges the mother was “never told what klebsiella was, or when or how her child had contracted it.” Instead, the nurses had “taunted” her, “saying mothers like her -- who gave birth at home -- brought the disease to the hospital. ‘They made it seem as if it was my fault that my baby had klebsiella. She was born at six months; she came before time and I had her at home before going to hospital,’” the baby’s mother said.” (“Sixth baby dies from Klebsiella”, 2007, December 6) Another article details the treatment of “A 66-year-old diabetic woman with multiple fractures [who] spent seven hours waiting for care at Helen Joseph Hospital in Johannesburg, while security guards threatened to use force to stop her relatives from caring for her. Despite her fractured foot and injured back and ribs, Anna Myers was asked to stand so that her chair could be used by other patients.” According to the woman’s son, “I was worried about my mom. She is sixty-six years old, she was in shock, her blood pressure was high, she is diabetic and she hadn't eaten anything. I asked the guards if I could please just get her some water before I left. They refused and demanded I leave or they would use force.” The article documents the patient’s progress through the hospital until, after seven hours of waiting without food or drink, she was admitted, only to be told there was no bed, and subsequently sent home without having received treatment. The newspaper further reports that negligence and malpractice has cost the Department of Health millions in damages awards.

Violations in medical practice: the research

Not only do such reports appear in the newspapers and in popular discourse from time to time but a relatively small body of research literature documents the violation of patients' rights by health care professionals. Within this small body of work, the majority deals with abuse of patients suffering from mental disturbances in psychiatric hospitals (see, for example, Saks, 2002, and Eriksson & Saveman, 2002). The subject of violation of patients by health professionals is therefore less well documented than it might be, given the serious nature of the events, their potentially serious consequences and the fact that the vast majority of people will find themselves dependent on medical care at some point in their lives. As Clarence and Sundram (1993) point out, this dearth of reliable research and data documenting such events may well be entwined with the same set of conditions that contribute to their occurrence, namely the climate within the relevant institutions, as well as those characteristics of the administrative and disciplinary structures of state institutions that preclude the reporting of abuse. The popular assumption that doctors' intentions are benign and that their motives are inevitably their patients' best interests further protects their conduct, to a large extent, from this kind of scrutiny (Katz, 1984).

Zaner (2000) argues, however, that the asymmetrical nature of the relationships between doctors and patients bears the possibility for doctors to take advantage of their patients' multiple vulnerable positions. As Lewinsohn (1998) points out, combined with the insensitivity characteristic of medical practice, this power imbalance creates conditions under which abuses could easily flourish. Indeed, on a continuum from relatively minor infringements to overt abuse, a number of authors have discussed actions on the part of hospital staff that violate patients' rights (Barber, 2007). Saks (2002), for example, describes such practices as the "spreadeagl(ing)" of a psychotic patient, Julia, to her hospital bed with thick leather straps that bruised her ankles and wrists, for having broken a plastic spoon during lunch. Such violations of patients by doctors and other hospital staff are reported around the world. Mizrahi (1986) reports the doctors' disparaging treatment and avoidance of patients, sometimes leading to their death, in a hospital in the United States. Zaman (2004) describes the routine humiliation of patients by hospital staff in Bangladesh. Andersen (2004) reports on differential treatment of patients based on staff prejudice in Ghana. And Malterud and Thesen (2008) discuss abusive practices in Norwegian health care settings. Such events thus occur globally and, according to Andersen (2004), are common throughout Africa.

D'Oliveira, Diniz and Schraiber (2002), in a review of studies documenting the perpetration of violence by health care professionals against patients between 1992 and 2002, argue that abuse occurs routinely in health care practice: "...Abuse and negligence seem intentional and commonplace events, an integral part of service routine, and not accidental episodes or perpetrated by a few bad staff" (p. 1682). These authors have further linked acts of abuse to negative health outcomes, arguing that violence, including neglect, verbal and physical abuse of patients by health care workers, is associated with reduced health-service access, quality and effectiveness. For descriptions of the alarmingly high incidence of cases in which patients suffer avoidable harm at their doctors' hands, see, for example, the 1991 US Harvard Medical Practice study conducted by Brennan, et al., and the Quality in Australian Healthcare Study, conducted by Wilson et al. in 1995. In addition to these large-scale studies, a paper authored by Iedema, Flabouris, Grant and Jorm (2006), "Narrativising errors of care," reports a wave of more recent studies of particular instances of medical failure, reporting figures as high as 8,3% of hospital admissions that result in avoidable adverse events.

What is going on?

The massive discrepancy between standards of practice, as set out in legislation and other documents detailing the requirements of ethical practice, as well as the commonsense assumption that sick people should and do receive compassionate care, and the acts of abuse described in the newspaper articles and research above, beg the question, 'What is going on?'

Reasons provided for the violations described by these authors are manifold and diverse. Professional norms of non-interference and the absence of effective professional regulation are frequently cited as major contributors (Mizrahi, 1986; Freidson, 1970a; 1970b; Millman, 1977), as are the routine medical proceedings, such as case conferences and ward round discussions, that help to sanction and neutralise errors that might otherwise be deemed the results of unacceptably bad practice (Fox, 1989; Atkinson, 1995). Some authors put forward the working conditions of hospital staff, in particular those in emergency units, where frequently inexperienced doctors work at the interface between the hospital and the community and are unprotected from the undifferentiated mass of mostly critically ill or injured patients flooding into the hospital (Jeffery, 1979). Others point to the practical constraints affecting delivery of care, for example the limited time available for each patient, impeding any intentions to provide patients with relevant information, to allow voice to their

concerns, and so on (West, 1984). And still others cite the myriad of justifications that health professionals use to deny or neutralise their involvement in events that might otherwise be construed as bad practice (Mizrahi, 1986; Dreyer & Geist, 1993). According to Scheeres, Slade, Manidis, McGregor and Matthiessen (2008) and Slade et al. (2008), ineffective communication has been cited as the most frequent cause of what they refer to as ‘critical (adverse) incidents’ in Australian healthcare.

While these and other authors have made some attempt to identify the reasons and conditions that lead to the perpetration of inhumane or abusive acts by health care professionals against their patients, there is very little research the specific focus of which is to provide such an explanation. (See Jewkes, Abrahams and Mvo, 1998, for one of the most substantial attempts to explain nurses’ abuse of patients in a South African maternity ward.) Rather, the majority of these authors make passing reference to possible explanations, leaving large expanses of the terrain uncharted. Of course some of the reasons, particularly in an overstretched health system like that of South Africa’s public sector, require little research to uncover. The recent illegal strike by doctors in South Africa speaks volumes about the extent of their dissatisfaction with working conditions, which have been described as “awful” by Zwelinzima Vavi, secretary general of the Congress of South African Trade Unions (“Vavi: Doctors’ salaries awful”, 2009, May 29). It is no great leap of logic to imagine that dissatisfied doctors who are poorly remunerated (earning between R9 791 and R19 048 a month, depending on qualifications) (Vavi: Doctors’ salaries awful”, 2009, May 29) for working shifts of up to thirty two hours in hospitals literally bursting at the seams, under the strain of too many patients, too few staff and insufficient equipment, are more likely to behave abusively toward their patients than are those who feel well rewarded for their work and get a good night’s sleep every twenty four hours. Excerpts from a further newspaper article illustrate the conditions with which doctors working in the public sector in South African hospitals are faced:

“It’s Monday and...three doctors are meeting the Mail & Guardian. ‘Why do we always have to fight and get the press involved for something to happen?’ asks Van der Westhuizen. The ‘something’ of which he speaks is a stable process for the procurement of basic equipment

needed in the hospitals. 'We've run out of Panado¹ and antibiotics,' he says. 'This means we have the option of giving patients morphine -- or nothing'.

After the meeting we are taken on a tour through Rahima Moosa and Helen Joseph...First is the labour ward of Rahima Moosa. Eight women, all of whom are already in labour, sit in plastic chairs in the corner of a room, waiting for beds to become available. Our 'tour guide' points out a scale next to a bed. 'For two years we didn't have scales to weigh the babies,' he says.

He shows us the resuscitation machine, which backs up what Zietsman told us earlier. 'We have 12 000 to 15 000 deliveries every year,' Zietsman said. 'And we have resuscitation equipment for only one baby. It's first come, first serve'.

... There is only one blood-gas machine in the entire hospital, says the doctor. . Van der Westhuizen had told us about this machine. It works using cartridges of chemicals. 'The company that supplies the cartridges won't give us any more because they haven't been paid in months,' he said. 'The hospital owes R180 000 to the company'.

In a consultation room a couple and their blanketed child sit in front of a mark on a wooden screen. The doctor points this out as the place where a blood-pressure machine used to be installed before it was moved closer to a power outlet. 'We ask for the equipment for so long,' says the doctor, 'so they put it up where it's not supposed to be, in this case without access to a power point. Then no one can use it and we have to wait weeks till they come back to install it properly'

Down the road -- at Helen Joseph -- the equipment situation is not much better. Until this month there was just one blood-pressure machine in the triage ward, an admission ward where doctors determine how urgently a patient needs to be seen... The department sees 100 patients a night and each patient's blood pressure needs to be taken. ...In the doctors' quarters the lock on the door has been broken for months and patients often come in and steal the doctors' possessions. ...The stairs...are strewn with dirty tissues and visibly dusty... We go up to the TB ward, which is the only ward in the entire hospital that has TB masks -- even

¹ Brand name for paracetamol.

though the tour-guide doctor says ‘most patients visiting our hospital are TB carriers and can infect other patients and also health workers...

As we prepare to leave Helen Joseph, we take one last look at a men's toilet. A rather unhappy cleaner sees us go in and asks: ‘Are you here to fix the toilets?’” (Rawoot, I., 2009, June 20).

The conditions described in this article, familiar to every doctor working within the public sector health care facilities across South Africa, make stress, frustration and anger understandable and produce inevitable responses on the part of doctors trying to function within them. However, while there can be little doubt that they play their part, I argue that these conditions cannot be invoked as the whole answer. Not all health care professionals abuse their patients or deliver healthcare in an inhumane fashion, despite overwhelmingly bad conditions. Thus questions seeking insight into why some doctors, and not others, operating in similarly stressful circumstances, respond in ways that are neglectful or more actively abusive of their patients remain unanswered. I argue that the answers to these questions hold the potential for contributing toward improving practice despite the hard realities of resource shortages and patient overload within the hospitals.

The contribution of this thesis

While the factors that produce and maintain the deplorable conditions of South Africa's hospitals are in dire need of attention, the relevant issues lie predominantly beyond the scope of psychological research and within the domain of such fields as economics, politics and policy formulation. My interest in this thesis is in exploring those features of the context within which health care is delivered that involve the more subtle factors that influence the manner in which health care professionals, and doctors in particular, work and respond to the constraints of the circumstances with which they are faced.

I set out in this thesis to explore these issues first by reviewing the existing literature on abusive and inhumane practice in medical care. The literature that specifically addresses abusive medical practice is small and under-developed in terms of the range of insights it has provided into the reasons for its occurrence. I will therefore review a relatively broad range of material that, while not necessarily explicitly intended to throw light on this topic, has

relevance for understanding how inhumane medical practices are made possible and even likely. The second chapter will therefore address discussions of medical culture, with particular reference to its core characteristics and to how these might enable inhumane practice. In the third chapter I will focus specifically on the identities produced and made available to doctors and patients within the context of medical culture, and on the implications of these for the relationships that develop between them and for the quality of care that doctors are likely to provide. In the fourth chapter I will review discussions of the workings of power within medical settings, exploring its interaction with medical culture and its ability to further entrench pathways to the delivery of inhumane care and the violation of patients' rights. And in the fifth I will review discussions of the operation of all these factors within specific local contexts, including the South African one, and as animated by particular individuals.

I will then go on to describe and report on the present study, which seeks to offer insight into the inhumane practices characteristic of the routine functioning of the emergency unit in a South African state hospital. In this regard I will attempt to show how the discursive context in which doctors' and patients' interactions take place allows for the ordinary occurrence of practices that in other contexts might be unthinkable. After outlining the methodological approach in chapter six, in order to contextualise my findings within the story of the research process through which they emerged, I will discuss in chapter seven the narratives in terms of which doctors structure and make sense of their worlds and experiences and establish their powerful position within these. In chapter eight, using their narrative landscapes as a framework for understanding the ways in which they discursively construct themselves, their patients and the events in which they are engaged, I will explore the identities available to doctors and patients within the emergency unit and the implications that these have for directing doctors' actions. Chapter nine highlights a theme that is latently present in the two preceding chapters, namely that of the relationship between doctors' attributions of agency and responsibility in the unit and a self-doubt that seems ever-present beneath the surface structures of their stories, and to which they respond with defensive reactions that further perpetuate a cycle of power and doubt, with negative consequences for the delivery of good quality care. Finally, in chapter ten, I will attempt to draw some conclusions as to the implications of this discussion for research and practice in medical settings and, even more importantly, for the possibility of producing change.

CHAPTER TWO

THE CULTURAL CONTEXT OF MEDICAL PRACTICE

Explanations of violations of ethical practice and patients' rights in medical care are widely dispersed across a range of perspectives in the literature that pertains to this topic, with only a handful of authors taking any given approach to the subject, and the majority working independently of one another within very different modes, and across a time span that extends from the 1970s to the present. Within this diverse array of work, only a few authors focus directly on explaining the occurrence of abuse and inhumane care. Many authors address aspects of medical culture and practice that can be argued to be highly relevant to such an explanation, but do so with other goals in mind, making no explicit link between their topics of discussion and the potential for inhumane action. And others refer only briefly to these possible associations, while maintaining a principal focus on other lines of thought.

In this review, I will approach the diverse work pertinent to my focus on inhumane and abusive practice, organising the material in terms of four broad and interrelated concepts, namely medical culture, the construction of identity in medical settings, power in medicine and the context-specific and individually-enacted animation of all of these themes. My aim in this review is to weave together the various threads that appear in the literature in such a way as to highlight their relevance for an understanding of how it comes about, all too often, that doctors act inhumanely and that patients' rights are violated in health care settings.

In this chapter I will explore the core components of medical culture as they appear in the literature, arguing that some of these contribute toward a climate within which the inhumane treatment of patients becomes thinkable and justifiable. Providing the framework within which the material covered in subsequent chapters is embedded, this chapter represents the weightiest of the four chapters that comprise this review. In chapter three I will focus this discussion to explore the treatment in the literature of the identities produced within this cultural context and will attempt to establish links between aspects of the identities available to doctors and patients, as described in the literature, and the possibilities for inhumane or abusive practice. In chapter four I will briefly discuss the power held by medicine as an institution. I will then explore those themes in the literature that illustrate the interrelationship

between relevant aspects of medicine's professional status and of medical culture and its associated identities with the power imbalances that exist between individual doctors and patients in medical settings. I will argue in this chapter that these highly interwoven features of the medical world further enable inhumane practice and the violation of patients' rights. Finally, in chapter five, I will discuss arguments for the context-specific and individually-driven manifestation of the various themes discussed in previous chapters within concrete settings and actual encounters between particular doctors and patients. Amongst these contexts, and most relevant to this research, is the South African setting. This chapter will therefore also briefly review the South African literature pertinent to these themes, in order to provide some insight into the context within which this research was undertaken.

Medical Culture

A significant body of work explores the culture that has developed within the medical professional body, showing many of its features to be universal to most, if not all, medical settings. Studies of medical culture are highly relevant to my aim in this thesis to explore the emergence of inhumane practices amongst medical professionals, offering insights from a position outside of the biomedical model and critiques of the assumptions that underpin the dominant forms of practice (Mishler, Amarasingham, Hauser, Osherson, Waxler and Liem, 1981). These critiques hold the potential to make recommendations not merely about how to increase the number of doctors in underserved areas, or to enhance the efficiency of existing systems, for example, but to facilitate more fundamental change that promises to affect "*how* biomedicine serves humanity" (DeVecchio-Good, 1995: p. 471, my emphasis).

A major arena in which medical culture has been addressed is that of medical education. Introduced by Fox's influential 1957 work, "Training for uncertainty," the body of work exploring socialisation within medical education foregrounds the existence of a medical culture into which students are socialised and that informs their subsequent practice. Authors who address this process emphasize the 'hidden curriculum' that dominates medical education, transmitting not only knowledge and skills but also values, beliefs and attitudes (Fox, 1989; Mishler et al, 1981; Mizrahi, 1986; Sinclair, 1997). While this body of work does address those aspects of medical education not explicit in the curriculum, but rather implicit in the subtexts through which senior doctors communicate to their students what is important and what is not, what is valuable and what is not, what attitudes and values are

appropriate for members of the profession and so on, the majority of this work remains uncritical of the core constructs on which the medical model is built, and thus offers criticism that falls within the medical paradigm, attempting to fine-tune the ways in which it operates and is transmitted to its student members, rather than to uncover and evaluate the dominant assumptions that underpin the biomedical model, to which Mishler et al. (1981) refer above.

A few authors working in this area do, however, adopt a more fundamentally critical stance, and it is their work with which I shall be primarily concerned in this review. I will not, however, give separate attention to studies that focus specifically on medical education as opposed to practice, as my focus is on the features of medical culture that have relevance for explaining inhumane practice, whether these are communicated within institutions of training or of practice. I will therefore discuss that material emerging from this body of work that is relevant to an explanation of inhumane practice according to themes that appear in the literature more generally. The unique contribution made by this body of work is the important recognition that medical education includes processes of socialisation and that the socialisation processes that medical students undergo affect their subsequent mode of practice. For example, authors including Mumford (1970), Mizrahi (1984; 1986), Fox (1989), Lupton (2003) and Good and DelVecchio-Good (1993; 2000) have explored the processes through which medical training impacts on the ways in which doctors perceive and relate to their patients, arguing that the structure of medical knowledge as taught in medical training encourages doctors to view their patients as diseases, and that the 'training in silence' that students receive contributes to doctors' later propensity to withhold from their patients information about diagnoses, treatments and other important decisions (Fox, 1989). I will review the work of these and other authors working within the area of medical socialisation at various points throughout the remainder of this chapter.

Probably the most used means for gaining insight into the socio-cultural dimensions of medicine is exploration of the language employed in medical settings. Since the focus of this review is on content rather than method, I will not detail the diverse methodological approaches taken by the various authors to the exploration of language. Suffice to say that those authors employing language to gain insight into medical practice do so with a very diverse array of aims and making use of a wide range of methodological approaches. Broadly speaking, however, this body of work can, from a methodological point of view, be divided

into two distinct categories. On the one hand are those authors who focus exclusively on the unit of talk being analysed, for example a particular conversation between doctor and patient (see for example ten Have, 1991; Heath, 1992; Sarangi & Roberts, 1999; Gill, Halkowski & Roberts, 2001; Stivers, 2006; Boyd and Heritage, 2006; Perakyla, 2006). This very substantial body of work, representing that which can strictly speaking be categorized as conversation analysis, was possibly the dominant approach to the investigation of language in medical settings in the 1980s, gathering momentum through the 1990s and continuing to the present, although with diminishing force. There are two major contributions that this literature has made with respect to the aims of this thesis. First, through its ability to empirically reveal the construction of medical knowledge between people, it has challenged the status of medical knowledge as objective and therefore unquestionable. And second, this body of work has abundantly illustrated the means through which medical domination is exercised within the micro-details of talk, thus articulating the linguistic mechanisms through which unequal power between doctors and patients is produced and maintained.

However, neglect of the broader contexts within which particular conversations are located represents a serious limitation of the extent to which this work has been able to offer insight into the meanings of talk for the participants involved, as well as the influences on and effects of these beyond the immediate conversational sequence. This limitation gave rise to a similarly linguistically-oriented body of work, but one that displays a more holistic approach to the analysis of talk, including aspects of its broader context, for example the events of the morning on which the relevant conversation occurred (Wodak, 2006a) or the broader social relationships and institutional contexts within which the conversation took place, in their interpretations. On a smaller scale, this work arose around the same time that conversation analytic approaches to the study of medical culture were flourishing and many of those leading the trend toward greater contextual awareness in the interpretation of language initially worked within this mode. Driven by a few authors whose works remain classics in the field to the present day, this movement began in the 1980s with the work of authors including Sue Fisher (1980; 1984; 1986), Elliot Mishler (Mishler et al., 1981; Mishler, 1984) and Candace West (1984; 1990). While strict conversation analysis has been heavily criticised for the reasons outlined above, this body of work has gathered an ever increasing number of adherents and at this point in time represents the more dominant of the two approaches, including a range of authors who tackle the investigation of medical settings

through a variety of approaches to language, including conversation analysis (see Maynard, 2003 for a detailed explanation of his incorporation of ethnography into the conversation analytic approach), discourse analysis (for example, Wodak 1996, 2006a; 2006b) and narrative analysis (DelVecchio-Good & Good, 2000). While these latter authors tend to be critical of the work of the former group, they have successfully employed many of the same and related methods for analysing language and interaction in the production of more contextually sensitive interpretations. While I will address some of the work of the former group in this review (mainly in the following chapter), to the extent that it offers important insights into the possibility for inhumane practice, it is the work of this latter cluster of authors, who adopt a contextually-driven approach to the analysis of language, with which I will be primarily concerned, as their work has greater relevance for the aim of this thesis to produce explanations for abusive practices rooted within the contexts in which they occur.

Overall, the most important contribution of this diverse array of linguistically-oriented work in terms of the aims of this thesis, is its treatment of medical talk as, not so much the elicitation and conveyance of independently existing information, but rather as social action that constructs, rather than reflects, biomedical material. This body of work thus highlights the social activities through which medical talk is produced by meaning-making beings (Donnelly, 1997; Lupton, 2003; Van der Geest, 2005), constituting medicine as a symbolically mediated activity, and its products, including case reports, clinical findings and treatment procedures (Good, 1994; Good & DelVecchio-Good, 1993, 2000), as constructions manufactured between all participants in the medical encounter (Dreyer & Geist, 1993), as together they respond to questions concerning what is taking place in any given situation (Rittenberg, 1985). Through its ability to supply empirical evidence of the construction of meaning between people in conversation, this body of work has thus highlighted the importance of the social context and of the relationship between doctors and patients for the form assumed by medical knowledge and practice. While, as stated above, this review covers a wide range of material from a diverse set of perspectives, this linguistically-oriented work represents the core of its focus. Those perspectives that do not offer critical insight into the ways in which broad medical and local hospital cultures enable abusive practices and the provision of inhumane care, including those that tackle doctor-patient relationships through the lens of patient-centred practice or shared decision-making - for example, those that address management issues in the delivery of quality medical care and those that focus on

biomedical ethics - are therefore not represented in this review. While these bodies of work no doubt have implications for humane care and the protection of patients' rights, the insights that they provide are not relevant to providing the social critique that is the intention of this study.

The relationship between medicine and broader society

Related to the above discussion of the importance of context is the issue of the relationship that exists between medicine and the broader society. A number of authors have remarked on the invisibility of medical culture and of the reciprocal influence of medical practice and the broader social environment on one another. Again, probably most influential in this area are the works of Elliot Mishler, Sue Fisher and Howard Waitzkin. (While Waitzkin's work is important for the field in general, its focus is divergent from that of this thesis, as his interest is not so much in inhumane or abusive acts by medical professionals as it is in the manner in which their attempts to relieve their patients' suffering simultaneously reinforce power relations between socially distinct groups, most notably in terms of gender and class. Waitzkin's work thus features only in a limited way in this review.) This theme, too, emerged in the early 1980s, although it was preempted by the work of Eliot Freidson in the 1970s, which continues to exert its influence on the shape of the field. In sum, these authors argue that biomedicine represents the lens through which the world is seen, obscuring the possibility that the biomedical perspective itself might be an object of study, and thus reinforcing the appearance of its neutrality. The major contribution of this discussion, as it weaves its way through the literature from 1980 to the present, to the aims of this thesis is that this characterisation of biomedicine as objective is responsible for the predominance of a tunnel vision that fails to account for the socio-political and ideological context within which medicine is produced and practiced. This tunnel vision perpetuates what Fisher (1995: p. 23) calls the "moral and political regressiveness that all too often accompanies it," and contributes to the possibility for acceptance of potentially hurtful and demeaning practices as stemming from the neutral application of objective knowledge, that is hence devoid of moral content and beyond criticism.

From this perspective, really understanding biomedicine and its practice involves looking beyond its parameters and asking how it responds and contributes to broader socio-economic forces (Mishler et al.,1981), thus uncovering the interests that shape medicine, both in terms

of its conceptualisation and its daily practice. Sue Fisher was amongst the first and most prominent authors to really flesh out a theoretical perspective for articulating the relationship between medicine and society and her work in this regard remains influential. Drawing on a perspective akin to that of Howard Waitzkin (see for example 1989; 1991), Fisher (1986) characterises the instances of medical practice as micro-level processes occurring within a context shaped by macro-level social structures, influencing one another in reciprocal fashion. In her own words,

“The web stretches from the spoken interactions of participants situated within specific medical events to the more general organisational and structural arrangements of society. It spreads from those structural arrangements out to the world view of the dominant culture, and then it folds back, spiraling in upon itself, returning to the core of spoken interactions” (p. 18).

Fisher’s contextual web metaphor, therefore, foregrounds the reciprocal and embedded nature of the relationship between medicine and its context, producing an understanding in terms of which medical culture can be seen to be “simultaneously created by its inhabitants and by the conditions in which they must exist” (Van der Geest & Finkler, 2004: p. 1999). Rather than a body of objective knowledge and neutral practices, medicine is thus conceptualised as a window into the culture in which it is located, rendering its most deeply held beliefs and values visible, as they are laid bare through participants’ responses to misfortune (Finkler, 2004; Zaman, 2004). Far from being an island separate from the rest of society, Van der Geest & Finkler argue that medicine should be viewed as the “‘capital’ of the ‘mainland’” (2004: p. 1998), replicating and continuing the features of the broader society, including its less than desirable ones. In the words of Lewinsohn (1998: p. 17), medicine, “like a vital organ in a sick body...suffers from all the ills of society at large: its degradation, its lack of an ethic, its fragmentation, its physical and spiritual pollution.”

As Fisher and Groce (1985) point out, understanding the cultural assumptions embedded within medical perspectives and practices facilitates insight into the influence of these on the delivery of health care. Different authors have focused on a variety of aspects of this relationship between medicine and the rest of society. Sue Fisher (1986) discusses the role of individualism in medical culture, arguing that, when combined with the ever-growing

medicalisation of social life, it lays the responsibility for illness and health care on the individual sufferer, obscuring the need for social responsibility in medical practice. Kaja Finkler, from an anthropological perspective, explores the relationship between the practice of biomedicine and the broad cultural milieus in which it is practiced (see, for example, her 1991 publication, in which she investigates the reciprocal influence of Mexican culture on biomedicine as practiced in that country.) And Shahaduz Zaman (2004) demonstrates the reciprocally reinforcing relationship between the hierarchical structures of the broader society and the social relationships within a hospital in Bangladesh. With a few exceptions, including Zaman's work, the majority of this body of work is relevant here only to the extent that it rests on the notion that medical practice and broader culture are interrelated. Its further relevance, however, lies somewhat beyond the boundaries of the work that I wish to explore in detail and that has relevance for my focus on inhumane practice. (For a relatively recent attempt to initiate reformulation of ethical constructs in terms of the relationship between medical practice and broader society, see Mishler's 2004 paper entitled "The unjust world problem," in which he advocates a heightened awareness of social inequity, and its consequences for the distribution of health and illness, in clinical practice.)

More immediately pertinent here is the work of those authors who have noted the differential treatment afforded patients who are members of marginalised social groups. Fisher (1984; 1986; 1991; 1995) focuses primarily on gender bias in the delivery of health care, compounded when female patients are also poor. Mizrahi (1984; 1986) has highlighted the salience of a wide range of social categories marginalised within the broader social structure, including those defined according to age, sex, race and class, members of which are likely to receive inferior care. Andersen (2004) has documented the replication of inequality in the broader society in a hospital in Ghana, showing how construction of relationships within the hospital in terms of the bureaucratic and structural organisation and of the social relationships in that broader society results in the provision of differential treatment to patients along these lines. And Katz (1984: p. 9) tells a story of a conversation he had with a French nephrologist that perfectly captures the mix of these prejudices with other discourses, in this case paternalism, in medical culture, enabling actions that might otherwise seem unthinkable:

"Immediately prior to our meeting the nephrologist had examined a French peasant who lived some forty miles outside of Paris and suffered from chronic renal failure. The condition was a

rapidly progressive one and would soon lead to death unless the patient was placed on dialysis. Yet the patient was not offered this option. Instead, he was told that no medical treatment existed that would help him. When I asked the nephrologist why he had concealed the alternative of dialysis from his patient, he reacted with surprise, as if the answer were self-evident: 'To say more would have been cruel. Peasants do not adjust well to a permanent move to a large city'. Dialysis would have required a permanent relocation."

From a related perspective, a number of authors have discussed the social origins of medicine and medical practice, arguing that its current form can be traced to its historical development. Authors such as Hogarth and Marks (1998), Rothman (2003) and Mishler et al. (1981) have illustrated the historical processes whereby patients have been objectified in medical thought and practice, the patient as subject being overshadowed by the medical case – an object. With the emergence of the hospital and the development of evidence-based medicine, doctors have come to focus on general patterns that can be identified in the ailments of categories of patients through technological means, the significance of the individual patients' narratives being diminished in the process. These developments have, in addition to contributing to a mechanical view of the sick body, and thence to the disappearance of patients' subjectivity, also furthered the development of an ever-growing gap between doctor and patient, a gap that continues to increase with doctors' specialisation and consequent focus on particular organs, and with the ever increasing external pressures to which doctors are exposed.

Informed by this understanding of the interrelationships between medicine and broader society, and underpinning the aims of this thesis, Fisher (1986) and others argue that strategies for change need to address not merely the practical aspects of health care but elements of the cultural framework within which it occurs that exert a potentially harmful influence on its delivery. Effective change should address not merely the technical advancement and efficiency of care but should tackle the cultural politics within which it is delivered (Lupton, 2003). As Van der Geest (2005) cautions, the conversion of contextual problems into technical ones is not only inappropriate but obscures the need for social change. Similarly, criticisms leveled at individual doctors, through their failure to address the social context within which the understandings and actions of these doctors are embedded, are unlikely to produce broad or lasting change (Andersen, 2004). This argument, emanating from the work of the authors discussed in this section, holds great potential for designing

interventions that are responsive to the 'invisible' forces brought to bear on medical practice and that, it is the implication of these authors, will continue to produce their effects until they are addressed and changed. However, this work does not appeal to the majority of those responsible for effecting change in medical practice and is overshadowed by less critical approaches with more readily applicable suggestions. It is perhaps a weakness, in these terms, of this rich and insightful body of work that more has not been done to render its findings immediately useful to practice.

In the remainder of this chapter I will review the various features of medical culture identified as relatively universal within the literature. Since this body of work is diverse, spanning approximately forty years and a range of differing paradigms of thought, I will attempt to synthesize relevant themes that occur within a sprawling mass, rather than a coherent body of work, articulating the interrelationships between them in a way that remains largely unarticulated in the existing literature.

The narrative of science

Amongst the most widely discussed elements of medical culture is that of the dominance of the scientific perspective within it. As pointed out by authors including Mishler (1984), Fisher (1986), Mizrahi (1986), Wodak (1996) and Lewinsohn (1998), science represents the point of entry into medicine, is prioritised throughout medical education and is pervasive in all aspects of its practice (Mizrahi, 1986; Fisher & Groce, 1990). The scientific perspective thus informs all action in medical settings, enabling and constraining the things that can be said and done (Donnelly, 1997), and blinding doctors to alternatives that might enhance or complement technological procedures (Lewinsohn, 1998). Exploring the ways in which this scientific perspective is structured and structures the practice of medicine, this body of work highlights the values implicit in medical knowledge and practice, challenging the claims of the medical profession to objectivity and thus foregrounding the unavoidably moral nature of their activities.

The scientific values of rationality, objectivity and neutrality inform the manner in which health care is delivered, and are argued to have facilitated a shift from humane to technological medicine (Mishler et al., 1981). While this issue is discussed by a large number of authors, perhaps Mishler's 1984 work, "The discourse of medicine: dialectics of medical

interviews,” has been the most influential over the last quarter of a century in its identification of two voices within the medical conversation, namely the ‘voice of medicine’ and the ‘voice of the lifeworld’. Referred to again and again by multiple authors working in the area, Mishler’s binary construction of medical and patients’ knowledge has been criticised for being overly simplistic but has also played a major part in shaping the field, through the relevant authors’ varying responses to it. Criticisms of Mishler’s construction centre predominantly around the argument put forward by authors such as Fisher (1991), Silverman (1987), Wodak (1996) and Atkinson (2004) that medical settings should not be understood in terms of a monologic discourse, all participants subscribing to or suppressed by one dominant voice. Rather, these authors argue that the medical world is constituted by multiple voices, sometimes in conflict with or in contradiction of one another. Indicating the massive gap and even conflict between the scientific perspective and that of the suffering patient, one of the most valuable implications of Mishler’s concept of the ‘voice of medicine’, however, is the emphasis it places on the narrative and meaning-laden nature of (scientific) medical discourse and its consequences for the relationships possible between doctors and patients. No longer directed by the question, “Why does it hurt?” the diminished focus of care is directed by the question, “Where does it hurt?” (Wodak, 1996). Assumptions concerning the biological specificity of illness implied by this latter question and the associated construction of doctors as scientists are shown by those authors concerned with this issue to have resulted in a variety of practices that have the potential to compromise the delivery of humane care.

Dominating all other frameworks of understanding, the scientific perspective leads, amongst others, to prioritisation of scientific endeavor over all other approaches to the treatment of illness. Successful practice depends solely on technological processes, and success is defined in terms of cure. All other knowledge and activity is deemed irrelevant to medical purposes (Mishler et al., 1981). Valuing only technical insights into the nature of illness, therefore, patients’ experiences are reduced to diseased organs and medical facts, and their bodies to machines (Helman, 2001), as stories told in the ‘voice of the lifeworld’ are translated through the medical encounter into ones structured by the ‘voice of medicine’. Caring actions, too, since they are not easily connected to specific and definable cure-related results, tend to be viewed as ineffective (Stokes, 1994). Talking with patients is thus downgraded in medical practice (Mishler, 1984), and treatment is administered instead through the use of

technical language that excludes patients from its processes (Wodak, 1996). In fact, in order to meet the scientific demand for generalisability, medical narratives of illness must necessarily exclude the unique experience of any given patient (Donnelly, 1997). Thus, technical and humane aspects of medical practice are split off from one another and attributed differential value, the emphasis being on technical procedures (Good and DelVecchio-Good, 2000; Atkinson, 1999 and Conrad, 1988).

The linear explanatory model offered by scientific medicine for the occurrence of illness, in its attempt to define a single cause, further tends to locate that cause within the individual, ascribing blame for bodily malfunctions to the patient concerned (Helman, 2001). Any actions on the part of the patient are, in turn, judged in terms of the criteria laid out by 'objective' scientific knowledge as rational or irrational, with similar consequences for patient blame (Good, 1994). Authors including Fisher (1986; 1995) and Waitzkin (1991) have argued that this perceived irrelevance of all perspectives and sources of information other than scientific ones obscures the potential importance of social factors for making correct diagnoses and recommending appropriate treatments. In addition to the consequent possibility for misdiagnosis and inappropriate treatment, ignoring the social contexts of patients' lives and experiences has been argued to constrain and even prohibit the possibility of humanistic relationships between doctors and patients and thus the provision of humane care (Mizrahi, 1986; Mishler, 1984).

The predominance of the scientific approach to medical practice has thus led to the association of medical competence with the values of objectivity. And the caring aspects of practice, including building relationships and displaying compassion, are associated with the humanities (Good & DelVecchio-Good, 1993). As Good and DelVecchio-Good (1993) and Mizrahi (1986) point out, this emphasis on 'curing' as opposed to 'caring' actions begins during medical training, within which only technical learning is rewarded and the more humane aspects of patient care are referred to, for example, as "sociological bullshit" (Mizrahi, 1986: p. 118). Medical education is thus organised around the diametrically opposed discourses of caring and curing, thereby separating patients from suffering people, juxtaposing technical activities with caring actions (Good & DelVecchio-Good, 1993) and enabling and justifying the callousness so often displayed by members of the medical profession in the delivery of technological treatments to their patients (Helman, 2001; Good

and DelVecchio-Good, 1993; Conrad, 1988; Mizrahi, 1986; Konner, 1997; Stokes, 1994; Mishler, 1984).

In opposition to this primary assumption in medical culture, Mishler (1984) argues that humane and effective care are, rather than mutually exclusive, inseparable from one another. He makes the bold argument that for care to be effective it must necessarily be humane, and thus that humane care *is* effective care. Mishler's argument is appealing; indeed there is no doubt some truth in it. For example, it seems intuitively true that a patient who feels that her doctor is listening empathetically to her will be more likely to provide a fuller history, rendering accurate diagnosis more likely, and so on. While the extent to which health care needs to be humane in order to be effective is a question to which the answer lies beyond the scope of this thesis, Mishler's standpoint is relevant in that it emphasizes the importance of humane care not merely for its own sake but also in terms of affecting health outcomes. Certainly, Mishler's point, namely that the biomedical model's stripping of the patient's social context from the doctor's understanding of his condition obstructs the possibility of his attaining a full understanding of that condition, and thus has the potential to impact negatively on the accuracy of diagnosis and appropriateness of treatment, represents a warning that should not be readily dismissed.

Objectification

In reducing patients' bodies and illness experiences to diseased organs, biomedicine simultaneously objectifies the patient, who is transformed from a suffering human being into the object of (scientific) medical knowledge and practice. In the words of Mishler (2005: p. 449), with reference to the very notion of a 'patient', 'There is always a person whose complexity and fullness is not captured by this characterisation.' This issue, with its associated (negative) consequences for the delivery of health care, in particular with reference to the interactions between doctors and patients, is widely discussed in the literature on medical practice.

Turner (1995) points out that the processes through which patients came to be depersonalised as objects of medical knowledge, rather than human subjects, are closely related to secularisation of the human body, in terms of which it came to be seen in scientific rather than theological terms. With Descartes's division between body and mind (Mishler, 1984)

and the rapidly developing relationship between the body and technology, the body was conceptually transformed from a mystical entity into a mechanical one (Potter & McKinlay, 2005). The development of this metaphor of the body as machine (Helman, 2001) was central to the development of medicine and the medical profession throughout the twentieth century. This mechanistic view of the body ushered in a new way of perceiving patients as composed of a series of mechanical parts, the patient himself or herself no longer greater than the sum of these. As machines, patients were no longer conceived of as spiritual beings but came to be viewed as without emotion, non-purposive, and therefore not meriting considerations of value, and fully understandable through objective means (Mishler, 1984). As illustrated in studies conducted by authors such as Good and DelVecchio-Good (1993), the development of this view of the body is not confined to a historical process that took place in the development of abstract bodies of thought and knowledge, but represents a process of inculcation that recurs and is continually reinforced as individual students and doctors progress through the medical system, coming to acquire increasingly machine-like views of their patients as objects and of themselves as mechanics (Dreyer & Geist, 1993).

Alongside these developments in scientific thought were related developments in institutional practice. A number of authors, most notably Foucault, have discussed the relationship between the rise of the hospital and the transformation of patients into cases. Bringing sick people together in the hospital ward enabled the identification of commonalities between them. Patients could now be classified in terms of these commonalities (Hak, 1999) and the patient's unique narrative, central to the past home visits of the local physician, became increasingly obsolete (Hogarth and Marks, 1998). In the words of Foucault:

“The process of bringing sick people together in the hospital, and of observing them and treating them as bodies that could be classified as cases, made not only biomedical science possible but in the same process, as the other side of the coin, the ‘sick man’... disappeared...” (as cited in Hak, 1999: p. 428).

With these developments, the medical curriculum came to be one of learning about standardised objects (Mishler et al., 1981) and the individual case became the object of medical knowledge (Good & DelVecchio-Good, 1993).

In terms of the basic scientific premise that anything that is real can be seen (Arney & Bergen, 1984), and the physiological specificity in terms of which biomedicine views the causes of disease, as well as the traditional perception of doctors as collectors of technical information produced by passive patients in response to their stimuli (Mishler, 1984), the patient's perspective on his condition, including anxieties and other concerns, is irrelevant to the medical diagnosis and treatment of disease (Fisher, 1991). The body is transformed from what Mishler et al. (1981: p. 224) call the "seat of subjective impressions" to the "site of specific disease entities to be detected and evaluated by the doctor independently of the patient." Suffering is thus removed from the concept of disease (Mizrahi, 1986) and patients' subjectivity is obscured from medical view, the illness having been appropriated by the profession (Mishler, 1984; Atkinson, 1995). DelVecchio-Good and Good (2000) show how medical students are taught to interact with their patients in such a way as to elicit 'medically important' information, and to edit out of their case presentations the patient's story, transforming the 'illness' into a 'disease' (Savett, 2002), and resulting, in many instances, in the deletion of the patient's lived reality from medical awareness. Finkler (2004: p. 2038) describes her experience of observing the practices associated with this perspective:

"...Perhaps most draining on me was witnessing the drama of the medical consultation, when patients reported the tragedies of their lives, and the doctors explored only the patients' physical symptoms. The physicians listened to the patients politely but did not hear when the patients described the squalor in which they lived as they were answering the doctor's questions about their symptoms."

Along with Mizrahi, these authors show how this perspective is communicated to medical students "from the first tutorial" (Good & DelVecchio-Good, 1993: p. 90) and continues to be reinforced as young doctors proceed through the system, taught by their seniors what is relevant and what is not through their expressions of boredom or impatience when presented with the 'irrelevant' details of patients' social contexts, as they yawn or snap their fingers to communicate the norm: "obtain just the [medical] facts" (Mizrahi, 1986: p. 96. See also, for example, Fisher, 1986; Apker & Eggly, 2004). Through this process, these authors show how not only the patient but his lifeworld disappears from medical reality. Along with the patients' life contexts go their emotions, construed as distinct from their physical distress (Cassell, 1982) and dismissed as irrelevant to medical understanding and intervention. Any

appearance of patients' emotions is negatively sanctioned as soon as it happens and, when suppressive measures fail, the patient runs the risk of her illness being classified as caused by her emotions (Fisher, 1986). Mishler (1984) argues that, through this process of defining what is medically relevant, the language of patients is absorbed by that of medicine, their subjective experience translated into scientific terms as their personal accounts are interrupted and their lifeworlds stripped away. With technological developments allowing doctors to make diagnoses even at the cellular level (Helman, 2001; Mishler et al., 1981), the patient's account of his/her illness came to be viewed as still less relevant and even invalid, possessing all the suspect qualities of subjectively based information (Atkinson, 1995). Patients' accounts are constructed as both inconsequential and invalid, juxtaposed against the medical history, for example, as fiction rather than fact (Arney & Bergen, 1984). If a discrepancy exists between the patient's account and the medical record, therefore, the former is dismissed in favour of the latter (Mizrahi, 1986). Indeed, doctors tend to mark patients' accounts as of questionable truth value, using rhetorical devices including words such as "states," "reports," "claims" or "denies" to precede narration of the information they have provided (Antaki, 1994; Donnelly, 1997). In contrast, words such as "shows," "notes" or "reveals" precede the accounts produced by doctors and by medical technology (Donnelly, 1997).

The depersonalisation of patients is thus grounded in the basic structure of medical training and practice (Mizrahi, 1986). The patient's body, in the eyes of the medical profession, becomes a medical body, different from those encountered in everyday social interaction (Dreyer & Geist, 1993), and the patient's identity is simultaneously transformed from that of social subject into medical object (Atkinson, 1995). As Helman (2001) points out, this transformation of the sick person into a case in a ward is aided by routine processes within the hospital, whereby the patient is surrounded by strangers, stripped of the usual identity props, such as personal dress, control of personal space and decisions - for example, what to eat and when - and transformed into a 'decontextualised' object in a hospital gown. This transformation of the patient's identity is reflected in and reinforced by doctors' talk, prescribed by medical and organisational culture that separates the person from the biological processes that are causing his distress. The patient is referred to by name and attributed with social characteristics only in the opening phrase of the case presentation and thereafter merely as an example of impersonal categories or in terms of such descriptions as are offered

by the numbers produced through laboratory tests (Atkinson 1995). Even in this opening phrase, social attributes ascribed to the patient tend to be limited, depicting a sick woman, for example, as “a thirty-seven year old black female” (Donnelly, 1997). The patient is thus presented as a ‘thing’ (Mizrahi, 1986) and his or her illness as an example of disordered biology (Donnelly, 1997). This process has been further exacerbated by growing specialisation. Training doctors intensively in the function of a specific organ or system increases the likelihood that they will lose sight of the whole (Rothman, 2003) and focus only on the affected part, reducing the patient to such an entity as a “stab abdomen” (Helman, 2001). It might be noted at this point that, while the focus in the literature is on how medical practice and doctors objectify patients, there are a few authors (see, for example, Heath, 2006) who draw attention to the dialogical nature of the process whereby patients are transformed into and treated as objects. These authors argue that, in presenting their bodies to their doctors, withholding their responses to disturbing procedures or diagnostic deliveries, and so on, not only doctors but patients in fact play a role in their own objectification.

The perspectives of doctors and patients are thus set up in opposition to one another, and the medical interaction becomes a process of translating lay explanatory models into medical ones (Helman, 2001). More than mere transactions between distinct points of view, a number of authors argue that the medical interaction is in fact a confrontation (Francis & Hester, 2004; Atkinson, 1995; Mishler, 1984; Hogarth and Marks, 1998; Kirkmayer, 2000), representing a struggle between conflicting agendas, namely the doctor’s with regard to biomedical evaluation of the patient’s complaint and the patient’s in terms of her personal fears, anxieties and life circumstances (Heritage & Maynard, 2006).

This process whereby the patient is denied as a human subject facilitates emotional distance between doctor and patient, a distance that, as much as it has negative consequences, protects doctors from suffering on their patients’ behalf (Goffman, 1961) and enables them to carry out invasive and potentially mutually distressing procedures, such as surgical ones (Mishler et al., 1981). It also enhances efficiency, the treatment of patients in terms of categories facilitating the smooth and effective running of the hospital system. And the more like an object the patient, the easier becomes the doctor’s work, diminished autonomy also rendering patients more likely to accept routine treatment. For these reasons, Lorber (1975) argues, the process of depersonalisation is frequently felt to be worth the price, all these consequences

bearing obvious benefits for the patient.

However, in another of that most influential cluster of works from the 1980s informing this field, Mizrahi (1986) argues that if efficiency was the only reason for the treatment of patients as objects, their subjection to disparagement would not feature amongst its consequences. While the consequences of particular actions are not necessarily related to the intentions that motivated them, Mizrahi's point certainly alerts us to the importance of increasing awareness within the medical profession of what are possibly the unintended consequences of various routine actions. In this regard, authors including Goffman, Mishler, Helman and others argue that the consequences of objectification can be serious, ranging from disrupted communication between patients and doctors to abusive actions inflicted on patients by doctors.

Mishler et al. (1981) argue that the problematic nature of many of the relations between doctors and patients derives from patients' objectification. The psychological distance thereby created between them has been argued to produce interactions characterised by distance, formality, brevity and the use of jargon, usually incomprehensible to the patient (Helman, 2001). Patients are frequently referred to on ward rounds in the third person, excluded from eye contact and generally treated as if invisible (Mizrahi, 1986). In the words of Goffman (as cited in Lorber, 1975: p. 213), objectification of patients produces "the wonderful brand of 'nonperson treatments' found in the medical world, whereby the patient is greeted with what passes as civility, and said farewell to in the same fashion, with everything between going on as if the patient weren't there as a social person at all, but only as a possession someone has left behind." Mizrahi argues that such interactions can confuse, frighten and hurt patients, affecting at least their psychological conditions, if not their physical ones. And Katz (1984) adopts the view that the human desire for recognition of "individuality, common dependence and equality" is profound, arguing that the "relief of suffering requires doctors' presence in the full sense of the word," (Katz, 1984: p. 208).

In similar vein, Mishler (1984) argues that the deletion of the patient as subject, and of the appropriation of her experience by the 'voice of medicine', at least seriously limits and possibly excludes the possibility of the provision of humane health care, which, he argues, depends on prioritisation of the patient's lifeworld as the basis for action. Instead of

encouraging or even allowing the 'voice of the lifeworld' to emerge in medical encounters, Mishler (1984: p. 127) argued that the dominance of the 'voice of medicine' "impairs and distorts essential requirements for mutual dialogue and humane interaction." In terms of the dualistic perception of mind and body, considerations of 'spirit', psyche, meaning and purpose are excluded from medical practice and patients, invisible as active subjects, are eliminated from participation in their own care, their feelings and beliefs disregarded (Mizrahi, 1986) and all aspects of their experience not classifiable in terms of scientific descriptions cast aside as irrelevant to medicine. These discarded concerns include humanistic ones (Lewinsohn, 1998) and doctors' perceptions of their role in relation to patient care are limited to a concern with biology. Any thoughtful consideration of who patients are or of their suffering are thus firmly placed outside the boundaries of medical activity (Savett, 2002). Authors including Katz (1984) and Helman (2001) refer to the compromise of key elements of the treatment process when the patient's subjectivity is unrecognised. For example, the principle of informed consent is based on that of self-determination, a concept that makes little sense when the subjectivity of the relevant 'self' is denied (Katz, 1984). And perhaps the disregard for patients' subjectivity described by these authors might represent a useful extension of the explanations offered by Turnbull, Flabouris and Iedema (2005) for the inattention displayed by staff in an intensive care unit in an Australian hospital to matters such as patients' dignity or possible humiliation in their forgetfulness of ordinary social requirements of etiquette, such as pulling the sheets over a female patient's exposed breasts or discussing the chances of a conscious patient's survival in front of that same patient.

The approach to medical practice that these authors describe excludes a whole range of material that Lewinsohn (1998), Fisher (1986) and Clark and Mishler (1992) have argued is relevant not only to humanistic interaction but in fact to both diagnosis and treatment, as well as recovery. Mishler illustrates the core of this argument in a comparative analysis of two medical encounters, in one of which the patient's story is heard and in the other it is suppressed. In his analysis he shows not only the relationship between the different approaches and treatment processes, such as the maintenance of a cooperative relationship between doctor and patient, but also the relationship between the extent to which the patient's story is told and treatment outcomes. These authors make a case for the relevance of Cassell's (1982) argument that the cure of disease and the relief of suffering, rather than distinct

activities, represent the 'twin obligations' of the medical profession if it is to be considered devoted to care of the sick. More than twenty years later, Mishler (2005), critical of the earlier narrow focus on the individual doctor-patient dyad, to the exclusion of social inequality, in which the causes of patients' suffering are often to be found, has extended this argument, emphasising the importance of an understanding of medical encounters that includes not only that which occurs between individual doctors and patients, but the larger health care system in which these interactions take place. This later turn that Mishler's work takes toward an integration of an "ethics of humane care" and an "ethics of social justice" (2004: p. 97), while broadly relevant to any discussion of ethical medical practice, moves beyond the narrower confines of my focus in this thesis, namely to explain the occurrence of inhumane or abusive medical practices. The direction that Mishler's work has taken, however, is likely to lead to further shifts in thinking in this area.

One of the relatively small number of authors who directly relate these themes to acts of abuse on the part of medical professionals, Mizrahi (1986) has discussed the relationship between the depersonalisation of patients and abusive action, showing how objectification is both the result and generator of hostile feelings of medical staff toward their patients. Mizrahi argues that objectification of patients in fact breeds contempt, quoting interns as explaining that denial of the human subject obviates the need for caring, and referring to instances in which patients become the objects of doctors' ridicule and verbal disparagement. Mizrahi uses her illustration of this process to explain the development of an attitude toward the delivery of health care that she terms 'Getting Rid of Patients' (GROP) Syndrome, in terms of which premature discharge and even death are construed as solutions to the problem of patient overload. In the words of one of the interns in her study, patients are transformed into "piece(s) of shit" (p. 34), which can justifiably be thrown out of any emergency room.

While a few authors, such as Dreyer and Geist (1993) and Arney and Bergen (1984) argue that depersonalisation in medicine is becoming a thing of the past and that the presence of the patient is reemerging within medical talk, their numbers are not great. In addition, their argument, namely that the scope of medicine is expanding to include not only the scientific but also the social and moral aspects of existence are somewhat beyond the domain of the arguments proposed in this thesis.

Medical culture and religion

Interacting with this dominant presence of science at the heart of medicine is the relationship between the institution of medicine and that of religion. This issue is discussed in any depth by only a very few authors, most notably Sjaak van der Geest, whose 2005 paper, “Sacraments in the hospital: exploring the magic and religion of recovery,” explores the interaction between medicine and religion in a hospital setting. However, a number of authors have noted the parallels between science and religion, as well as the convergence of the historical development of these institutions (Fox, 1989; Good, 1994; Obholzer, 1994; Kellerher, Gabe and Williams, 1994). This area of work does not form a significant body within the field that addresses the issue of medical culture, but has significance for the aims of this thesis, nevertheless, and is therefore worthy of discussion.

Van der Geest (2005), amongst others, points out that doctors in modern society have come to assume the role previously occupied by priests. Indeed, the medical and religious professions were once the same, priests exercising both religious as well as healing duties, a practice which continues in some cultures and even persists, to some extent, in Western culture, as priests are considered to have certain healing powers and are in fact expected in many instances to exercise magical powers (Obholzer, 1994). Doctors have thus come to represent society’s defence against death (Obholzer, 1994), a commonality between medicine and religion, that exists not only on a symbolic level (Van der Geest, 2005) but one that authors such as Kelleher, Gabe and Williams (1994) remind us has distinct material reality, in that doctors are in fact the ‘gatekeepers’ to access to life-saving drugs and medical procedures. In addition, authors such as Millman (1977) and Mizrahi (1986) observe the disturbingly real enactment of this role as doctors take decisions about who will receive what treatment, and consequently about who will live or die. Thus, a note scribbled by a doctor on a patient’s chart, or an implied but unspoken agreement between doctors may serve as an instruction not to resuscitate a patient should he experience a life-threatening condition.

With the decline of organised religion, Kelleher et al. (1994) argue that doctors are not only required to heal physical ailments but also to offer advice on how to live the good life, through definition of healthy practices. Having access to what van der Geest (2005: p. 139) terms ‘the most relevant physical reality’, namely the human body, doctors are able and required to formulate the rules for good living. As Fox (1989: p. 150) points out, hospitals

are, in addition, constructed around “the perils of human existence” and, as the places in which a great many people are born and die, they are charged with concerns about the meaning of life, good and evil, mercy and justice and so on. In the author’s words,

“In the hospital the comedy and tragedy of human existence, its nobility and its ignominy, lie close to the surface, are juxtaposed, and intermingle. Not only do people’s life stories begin and end here, but they are elicited and revealed, in all their sameness and variety, while the overseeing ‘central clock that is to be found in practically every hospital unit’ ticks neutrally and endlessly on” (Fox, 1989: p. 151-152).

Thus, birth, death, suffering, care and cure, along with the experiences of hope, anxiety, trust, doubt and so on that they evoke (Van der Geest, 2005), are religiously resonant experiences and part of the everyday life of the hospital.

This area of work, while small and having exerted limited influence on the rest of the field, is nevertheless important as it has major implications for the powerful position that doctors occupy, as well as for the relationship between the medical profession and society. In this sense, the discussion of the relationship between medicine and religion is of particular importance to the aims of this thesis, having implications both for the fact that doctors and the medical profession hold immense power and for the unquestionable status attributed to their acts and decisions.

Certainty vs. uncertainty

The combination of the scientific and religious aspects of medicine and the medical profession, with the status and expectations they have acquired in society, and the god-like nature of the decisions doctors are required to make, set the scene for the construction of doctors as omnipotent and in possession of knowledge that is certain. Renee Fox’s seminal 1957 work, “Training for uncertainty,” which continues, half a century later, to represent a key work in the area, and in which she argues that medical students are trained to deal with the *uncertainty* inherent in medical knowledge and practice, has spawned a discussion centered on the tension that exists between certainty and uncertainty in medical thinking and practice. Fox’s work, while engendering probably as much criticism as it has respect, has initiated a discussion of the role played by this tension in medical culture, which is argued to

have huge implications for the possibility of ethical medical practice.

Opposing the view proposed by Fox that medical students are trained to deal with the uncertainties inherent in medical knowledge and practice, authors including Katz (1984), Atkinson (1981; 1984) and Allsop and Mulcahy (1999) have argued that they are trained instead to adopt a standpoint of certainty, defending themselves against their own unanswerable questions, doubts and anxieties, as well as those of their patients and of the broader society. These authors thus argue that doctors are, in contrast to Fox's claim, trained for certainty (Atkinson, 1984). However, they alert us also to the existence of a paradox in terms of which the omnipotent status and the position in which doctors are placed, and which they assume, coexists with an inherent and unshakeable uncertainty that pervades medical knowledge and practice. Evidence for the reality of the uncertainties of medicine lies in statistics suggesting that between six and sixteen percent of visits to the hospital actually cause a deterioration in the patient's health, and three to four percent result in permanent disability or death (Finkler, Hunter and Iedema, 2008). This combination of omnipotence and uncertainty, it is suggested in the literature, provides the motivation for the profession's insistence on its authority and on its sole capacity for regulation of its own activities and for the development of the culture of silence that pervades medical practice.

Uncertainty and authoritarianism

It is widely accepted amongst researchers in the field that the medical context is indeed filled with uncertainty for all concerned – uncertainty regarding the nature of the presenting condition, uncertainty regarding the patient's likely response to treatment and uncertainty regarding the potential outcomes of the healthcare process (Martin and Dreyer, 2001). Medicine has assumed the status of 'hard science', but both the human body and disease remain highly dynamic and therefore unpredictable. In contrast to Fox (1957), Atkinson and others have argued that the process of medical training, instead of equipping students with the skills and resources to deal with inevitable uncertainty, primes them to deny its existence and to assume the possession of absolute knowledge, and the authority associated with it (Atkinson, 1995). While authors such as Rosenthal (1995) and Katz (1984) emphasize the importance of authoritative confidence in medical decision-making, which often needs to be conducted with immediate effect, these authors, as well as Erickson (1999), also note the potential consequences of doctors' attempts to "clutch... certainty out of the jaws of

uncertainty” (Erickson, 1999: p. 119), arguing that their vain attempts in this regard can lead to such attitudes as diagnostic dogmatism and authoritarian, rather than authoritative decision-making.

The doctor’s position is, however, more complex than might be surmised from this single aspect of the discussion. Mizrahi (1984) goes on to discuss the self-doubt that “gnaws” at doctors when, for example, a patient dies. Although only taken up by a limited number of authors in the field, this relationship between uncertainty and the self-doubt that is prevalent amongst doctors was first raised by Fox as far back as 1957 in her categorisation of the uncertainty inherent in medicine in terms of three dimensions: First are the limitations of medical knowledge. Second are individual doctors’ own limitations due to the impossibility of complete mastery of all aspects of the field of medicine. And third, arising from the combined existence of these, is the doctor’s difficulty in determining which of the two is predominant in any particular instance. Fox describes what she terms the “emotional, moral and existential” conundrum this creates for doctors, faced with uncertainty in the face of dire situations:

“To be puzzled, ignorant, unable to understand; to lack needed knowledge or relevant skill; to err, falter or fail, without being always sure whether it is ‘your fault’ or the ‘fault of the field’ ...is especially painful and serious when the work that you do is medical” (Fox, as cited in Atkinson, 1995: p. 114).

Within this context, rather than the opportunity to confront uncertainty and potential error, doctors are encouraged within the cultural milieu to defend themselves psychologically against it. Doctors’ defences against uncertainty also avoid the shattering of their omnipotent status that might occur should they engage openly and honestly with their patients and others about the realities of the limitations of medical knowledge and their own fallibility (Katz, 1984). Thus, doctors are encouraged to withhold information from their patients, justified and reinforced by the paternal dimensions of medical culture, in terms of which the patient’s absolute faith in his doctor is construed as necessary for cure (Millman, 1977). Believing that patients can neither comprehend nor emotionally manage the complex and pervasive uncertainties with which medical knowledge is fraught, doctors are discouraged from revealing these, or possible disagreements between the experts regarding the nature of a

patient's condition or the best available options for her treatment. A culture of silence is thus entrenched in the medical profession and the withholding of information from the patient is justified.

Self-regulation

Professional self-regulation is a concept that has become prominent in discussions of medical culture and the medical professions, primarily through the highly influential work of Eliot Freidson during the 1970s, who addressed the matter in his sociological analyses of the organisation and practice of medicine. The issue remains of interest to the present day, and is particularly prominent in the work of those authors dealing with medical error and malpractice. Arising from the high levels of uncertainty and perceived infallibility discussed above, the general consensus that only a doctor can judge the performance of another doctor is the consequence of what Rosenthal (1995: p. 27) describes as a “cumulative logic of permanent uncertainty, necessary fallibility, shared personal vulnerability, understanding and forgiveness...” And it results in not only doctors' reluctance to criticise one another but also in the fact that only the grossest misdemeanours are ever given disciplinary attention (Allsop & Mulcahy, 1999). Since the notion of accountability is reliant on the sanctioning of the actions of groups or individuals by a larger collectivity, which itself includes those affected by the relevant actions, the accountability of the medical profession and of individual doctors within it is seriously called into question (Mizrahi, 1984). It is noteworthy that when errors do occur and are discussed, Rosenthal reports that doctors tend to shift footing, no longer proclaiming a position of certainty and infallibility but emphasising the uncertainties in the process that led to the relevant negative outcome.

Thus, according to Rosenthal (1999) and a number of other authors who have investigated the ways in which medical errors and poor outcomes of medical treatments are handled by the profession, pervasive uncertainty engenders a sense of solidarity between members of the medical profession, producing a sense of shared vulnerability, and hence leniency, when it comes to mutual criticism. These two elements of the world of medicine, namely uncertainty and collegiality, represent, according to Rosenthal, the ‘twin pillars’ of its culture, forming a dangerous mix, in terms of which doctors are protected to a very large degree from the likelihood of criticism by colleagues and are shielded from their own feelings of responsibility when things go wrong. They are thus able to identify with the collectivity and

so spread the responsibility, rather than perceive themselves as personally culpable (Mizrahi, 1984). A norm has developed within the culture of medicine in terms of which the doctor's competence is assumed. In keeping with his superior status, he is not checked up on; instead, the maxim "Thou shalt trust physicians" is preserved and adhered to in medical settings (Freidson, 1975: p. 124). Deviance from this norm, rather than poor medical practice, is discouraged by the profession, as is evident, for instance, in examples provided by Mizrahi in her 1986 study (p. 31), in which she describes a situation in which a new and relatively senior doctor reprimanded one of his juniors on his decision not to resuscitate a patient: "The gossip that ensued...demonstrated 'the norm of non-interference'." Thus, Rosenthal and others (Millman, 1977; Mishler et al, 1981; Paget, 1988) note that the collegiality found within the medical profession has "many faces," ranging from mutual esteem and support to closing of ranks against patients and others and protecting the profession's own interests at the expense of outsiders.

Silence

As noted above, amongst the consequences of the assumption of authority and claim doctors make to medical certainty, and the self-regulatory position of the medical profession is the culture of silence and the norm of withholding information from patients. This theme emerges in the work of a great many authors with a diverse array of aims and perspectives, from those writing about the ways in which medical practice in its current form can be honed and improved, to those adopting a critical standpoint to the assumptions underlying medical practice, to those concerned specifically with abusive practice and the violation of patients' rights. From the point of view adopted in this thesis, two works emerge as most important in this area, namely that of Millman (1977) and of Katz (1984). In a highly influential work that explores the centrality of silence about medical error to medical culture and practice, Millman argues that the paternalistic quality of medical practice that comes with its authoritative stance means that doctors routinely withhold information from their patients both about their illnesses and about the wisdom of other doctors' decisions (Millman, 1977). In terms of this paternalistic discourse,

"Even if patients ask to be told everything, you shouldn't necessarily listen to them. You can't just tell people things because they say they want to know, because they're curious. Children are curious – they always want to know things – are you going to tell them

everything they want to know? No, you don't load up a child with the weight of knowledge and you can't do it to patients either" (Millman, 1977: p. 149).

Millman argues that, while decisions to withhold information from patients are indeed sometimes taken with the intention of protecting them from what their doctors believe they can neither understand nor cope with, such decisions are also sometimes taken with the doctor's interests in mind. The less patients know about their conditions and treatment, the less trouble they can make for their doctors. Medical culture thus promotes silence, hiding even the possibility for error and misjudgement before they have had the chance to occur.

The argument against this culture of silence is eloquently conveyed by Katz (1984), in a sensitive, insightful and compassionate analysis of the mute engagement of doctors with their patients. From a psychoanalytic perspective, Katz argues that the requirement of informed consent is intended to protect patients from the sense of abandonment they suffer when treated with silence and that patients need to know what is wrong with them, what the possibilities for treatment are and what their prospects of recovery are thought to be, in order that they might assume responsibility for their lives and illnesses. Like Millman (1977), Katz argues that this information is repressed in favour of professional interests, protecting the profession at the patients' expense.

While these works, in particular that of Millman (1977), have exerted their influence on the formation of this field, little has emerged in the area since that offers similar depth of insight into the silence that pervades medical practice. More recently, in work carried out in the emergency department of an Australian hospital, Scheeres et al. (2008) observed the state of confusion in which patients were left with regard to the workings of the hospital system. These authors note the time and clinical pressures under which emergency medical staff work as the reason for their omission to provide much needed information. This somewhat limited interpretation of the hospital staff's silence might be extended by reference to such factors as the paternalistic constructions outlined by Millman, Katz (1984) and others, which perhaps interact with the more pragmatic concerns of Scheeres et al to render the option not to inform the patient readily available.

Masculinity in medical culture

Related to this authority that doctors assume relative to their patients, and on the grounds of both superior scientific knowledge and unassailable wisdom, is the presence of traditional constructions of masculinity in medical culture. The traditionally masculine features of medical culture are widely discussed with respect to its paternalistic nature, a characteristic that was taken for granted as the natural order of things and as a desirable state of affairs prior to the 1970's (for example, Talcott Parson's functionalist perspective, through which his notion of the 'sick role' was seen to lead to a parent-child-like relationship between doctor and patient), when criticisms of the dictum, 'trust thy doctor' began to become audible. The image of the paternalistic male imbues doctors with the authority to make decisions and the right to withhold relevant information from their patients, through its invocation of his all-powerful but benign and protective intent toward his inferiors.

A much more limited number of authors, however, refer to a broader range of images than those invoked by the paternalistic father-figure, also derived from the traditional masculine ideologies that pervade medical discourse. Authors such as Wicks (1998), noting the importance of metaphor in shaping knowledge and experience, and hence doctors' attitudes to the practice of medicine, argue that understanding of these metaphors is not only important in comprehending the forces that drive particular practices, but also provides the basis for subverting those forces that support problematic practices (Wicks, 1998). For example, Fisher and Groce (1990) point out that both masculinity and status are associated with strength and femininity and lack of status with weakness. The implication of this is that those actions performed by doctors that are in keeping with traditional masculine identities and ideologies will be more likely to acquire them status than those actions, such as caring ones, traditionally associated with femininity. Thus, doctors' understandings and evaluations of their own and each others' competence are interrelated with broader cultural understandings of gender (DelVecchio-Good, 1985). This creates pressure for doctors to conform to particular culturally produced stereotypes, in this case, those embodied by Sir Lancelot of King Arthur's round table (Drife, 1998).

Again one of the landmark texts with respect to the manifestation of masculine metaphors in medical culture derives from the 1980s. Mizrahi's 1986 work, "Getting rid of patients," referred to already in this review, and to be discussed with reference to themes of masculinity

below, provides a vivid illustration of the transmission and enactment of traditionally masculine values, amongst others, within a hospital setting. Other authors, while their endeavours have left less of an imprint than Mizrahi's, perhaps, have also produced some key studies, more singularly focused on masculinity in medicine. Erickson (1999), for example, has described the presence of what he terms 'medical machismo' in medical culture, in terms of which the doctor's script is one of heroic action and the 'real doctor' is not merely technically competent and committed to his patients but takes on the identity of the 'lone ranger'. In similar vein, Cassell (1992), in an investigation of surgeons, explores the everyday talk and behaviour in which the surgeons in her study engage, showing their talk to be comprised mainly of subject matters such as sport and cars; and their behaviour to include such propensities as a refusal to wear safety belts or overcoats, even in subzero temperatures. Cassell further brings into relief the pervasiveness of masculine ideology not only in peripheral conversation but in surgical discourse itself, in which the surgeons in her study are described as needing "balls" to do their jobs and as "invulnerable, untiring, unafraid of death and disaster" (p. 173). In fact, she quotes one of the participants in her research, providing an explanation for a colleague's success as a well-respected surgeon, which he attributed to his characteristics as "smart, aggressive and a little bit of a son-of-a-bitch" (p. 177).

The military metaphor

Amongst the metaphors within the repertoire of traditional masculinity is the war metaphor, one that has been argued to have particularly disturbing consequences for the construction of doctors' and patients' identities and for medical practice. Cassell's (1992) study of surgeons further provides quotes in which surgeons describe their occupation as a "brutal" game and argue that "you have to approach an operation like a battle" (p. 174). Mizrahi's (1986) primary contribution to the discussion of masculinity in medicine also centres on the military metaphor. She shows how this metaphor affects medical students' understandings of their identities and purposes, and of the means available to them, arguing that the students she studied viewed all of these through a lens applicable to combat, rather than caring action. Students and new doctors described their experiences as "being ordered into the trenches" (p. 3) and as representing the "first line of defence against disease and trauma" (p. 3). Authors such as Wicks (1998) have produced similar findings, quoting doctors who described their experiences as akin to being on the frontlines, and, in discussions about the health care they provided, using words such as "aggressive" and claiming to employ means such as "shotgun

therapy.” The military metaphor extends not only to doctors’ constructions of themselves and their work but also to their understandings of disease itself, which, in these terms, becomes an invading enemy (Arney & Bergen, 1984).

Perhaps most disturbing of all, however, is the associated construction of patients in these terms, who become, within this combative context, the ultimate enemy (Mizrahi (1986). Both Mizrahi and Wicks (1998) produce numerous examples of medical talk in which patients are described using words that connote violence and military action. For example, Mizrahi argues that use of the word ‘hit’ to describe a patient who is admitted evokes images of air strikes and, through use of the word in military contexts to refer to enemy planes, ships and so on that have been struck in an attack, even reduces the patient to enemy material. Other violence-invoking language that Mizrahi’s doctors used to describe their dealings with their patients included phraseology such as “crashing and burning,” “getting killed” and being “under fire.”

The importance of action

Associated both with traditional masculine ideology in general and with the military metaphor in particular is the importance of dramatic action in defining worthwhile endeavour and success. Authors including Erickson (1999), Katz (1985) and Millman (1977) have provided insight into the role that this value plays within medical practice, the central argument being that the importance placed on dramatic action leads to more positive evaluations of decisive acts and a devaluation of actions that progress thoughtfully and carefully (Katz, 1985). Thus, what Erickson terms “stunningly insightful diagnoses in the midst of competing possibilities” (p. 119) feature amongst those actions that are esteemed and that doctors are motivated to accomplish, whereas management of conditions that do not lend themselves to certain diagnosis or that cannot be cured are undervalued and even sneered at by ‘successful’ doctors (Erickson, 1999; Millman, 1977). Within a context in which medical practice is construed as the exertion of power over disease and physical decline, such actions, that fail to produce immediate and tangible results, are equated with “doing nothing,” (Hahn, 1985) the only relevant response to an ailing body being to “figure it out and fix it” (Good & DelVecchio-Good, 1993). Thus, doctors are driven to define problems, do something about them and see results (Cassel, 1992). By implication, those problems that fall outside of these narrow parameters run the risk of being defined as

unworthy of their time. Not only are problems that are not amenable to such action or that are unlikely to yield the desired results dismissed on these grounds, but actions themselves that are not deemed likely to contribute directly to this chain of events are similarly dismissed as pointless and even as cause for embarrassment on the part of their agents (Konner, 1997). In his study, Konner, for example, found doctors to be more likely to be embarrassed when observed speaking words or performing actions that were not entirely instrumental than by brusqueness, the slow and undramatic nature of caring actions being viewed, in these terms, as ineffective (Stokes, 1994).

The dichotomy established through the dominance of the scientific narrative in medical culture, in terms of which caring and curing actions are diametrically juxtaposed, is thus reiterated through the operation of metaphors of traditional masculinity, further reinforcing the placement of effectiveness and humaneness in opposition to one another, as reflected in the quote from a doctor to which Mishler (1984) refers: “Do you want to be a nice guy or a good doctor?”

Summary

In this chapter I have attempted to weave together those threads in the literature addressing the institutional power of the medical profession, as well as medical culture, that are relevant to the arguments proposed in this thesis. I have attempted to synthesize these in such a way as to show their interrelationship and the logical train by which they might be argued to enable inhumane and abusive medical practice.

I have discussed those themes in the literature that explore the social context of medical practice, identifying key elements of medical culture that emerge in the literature as common to the majority of medical settings. In this respect, I have described how the various aspects of scientific, religious, and masculine discourse as represented in the literature are interrelated, weaving together the most prominent themes and showing how they relate to the potential for inhumane or abusive care. Tracing themes in the literature that pertain to the contradiction that exists between the assumptions of infallibility and associated authority, and the uncertainty inherent in medical knowledge and practice, I have further explored in this chapter those threads that discuss the self-doubt and defensive responses exhibited by doctors, highlighting the potential for these, too, to lead to inhumane or unethical practice.

CHAPTER THREE

CULTURE AND IDENTITY

Discussed as a core point of focus by only a few authors, but emerging as a theme that threads its way through the work of many, is the construction of doctors' identity in medical culture. In this chapter, I review that work that focuses specifically on the production of identities within medical settings. Those authors who make reference to this issue argue that not only medical knowledge and practice but also doctors' selves and self-concepts are produced through the process of their training, transforming students into doctors, with all the associated 'doctorly' characteristics (Mishler, 1984; Good & DelVecchio-Good, 1993). Authors such as Cicourel (1999) note that this process begins even before the first class is held, as selection procedures cast students allowed entry into medical school as 'special'. Thus, the effects of medical socialisation on doctors are deep, affecting not merely their professional behavior but their thoughts, feelings and most personal values.

Approaches to the discussion of identity

Those authors who address the issue of identity do so from a variety of angles. Good and DelVecchio-Good (1993) explore what they refer to as the 'reconstitution' of medical students' identities as part of the process of socialisation undergone during medical training. Martin and Dreyer (2001) address the matter making use of the idea that individuals are positioned relative to one another within particular social settings. And Fox (1989), Weiss (1993) and Apker and Eggly (2004) have discussed the production of doctors' identities through medical practices such as grand rounds, case conferences, morning report and other discursive practices. Other authors have taken different approaches, exploring, for example, the narrative reproduction of medicine's cultural milieu within doctors' autobiographies (Pollock, 2000) and the manner in which the penetration of the medical gaze into the body directs the formation of doctors' identities (Arney & Bergen, 1984). And Cassel (1992), in her study discussed in the previous chapter with reference to the masculine attributes of surgeons, goes so far as to claim a personality specific to surgeons. She argues that surgeons generally display attributes well-suited to the tasks that they perform, suggesting that the job of cutting into human flesh tends to be associated with such characteristics as machismo, omnipotence, arrogance and a tendency to paranoia.

Apker and Eggly (2004) show how, within routine practices such as morning report, communication is employed in the construction of identities consistent with the principles of biomedical culture. And again, the importance of science as the basis of medical knowledge, culture and practice is central to some of the core works that explore the production of doctors' identities. Both Mishler et al. (1981) and Good and DelVecchio-Good (1993), for example, argue that medical students' and doctors' perceptions of themselves as scientists is fundamental to their understanding of their professional and personal identities. Not only does the medical profession prioritise scientific activity, therefore, but doctors actually take on the identity of scientists, adopting the associated values of rationality, objectivity and neutrality (Mizrahi, 1986; Mishler et al., 1981). Mishler et al. (1981), Mizrahi (1986), as well as Apker and Eggly (2004) have argued that the identity of bioscientist, to which doctors generally aspire, exerts a profound influence on the way in which medicine is practiced, promoting the value of objectivity, marginalising humanistic approaches to medical practice and emphasising the value of scientific accomplishment, irrespective of the patient's needs. In the terms used by Strong and Davis (1978), identities are associated with rights that can be invoked to make possible and to justify certain actions, doctors sometimes employing these to force particular lines of action within medical encounters.

A number of authors who have addressed the issue of identity in medical practice have stressed its dialogical nature, emphasising the production of identity in the interaction between doctors, between doctors and patients, and between doctors and other staff within the medical setting. Fisher (1986; 1995), and Fisher and Groce (1990), in particular, have explored the negotiation of identities within the medical consultation, arguing, for example, that the construction of patients as incompetent reinforces the competence and powerful position of their doctors, and that not only doctors but patients, too, are active participants in these negotiations. Thus, not only do the medical profession and its members influence the construction of doctors' identities, but patients, too, exert their own influence, albeit frequently in the form of expectations derived from the values and images put forward by the medical profession. For example, patients frequently expect authoritative superiority from their doctors, such expectations constraining the extent to which doctors can assume alternative identities (Dreyer & Geist, 1993).

Doctors as bioscientists

As discussed in the previous chapter, in terms of the dominance of the scientific perspective in medical culture, doctors are shown in the literature to assume the identity of bioscientists. Also discussed in the previous chapter, amongst the more disturbing corollaries of this identity is the fact that admission of uncertainty or, worse still, of error, becomes an unacceptable flaw in the self-confident facades that doctors must wear (Millman, 1977). The identity of doctors as bioscientists is thus tightly bound up with constructions of medical knowledge as certain and true and with medical definitions of competence in terms of potency in the exertion of power over the realities of disease and death (Good & DelVecchio-Good, 2000). In the words of Obholzer (1994: p173), “Doctors are caught up in the societal fantasy about their omnipotence, an unconscious social projective system in which the capacity to do heroic things is imputed to them, and they are expected to perform.” As discussed with reference to their silence on matters of uncertainty and error, the threat posed by the discrepancy between these expectations and the reality produces a situation in which individual doctors battle with self doubt and patients remain unprotected from their doctors’ attempts to conceal their vulnerability through, for example, withholding information and suppressing error (Millman, 1977).

Group identity

The discussion of identity in the medical profession refers to both individual and collective dimensions and a number of authors have noted the existence of a ‘collective identity’ that members of the medical profession share. Again, Mizrahi’s work is prominent in reference to this topic and she, along with Fox, Good and DelVecchio-Good, amongst others, has investigated the socialisation process that medical students undergo on the way to becoming doctors and beyond, noting that much of medical education involves learning what it means to be a member of the profession. Not only are the identities of individual doctors thus shaped through their socialisation in medical training but the ‘rites of passage’ that medical students undergo bind them together and set them apart from anyone outside of the medical fraternity (Fox, 1989). The identity of bioscientist to which doctors aspire further sets them apart through their associated employment of discourses that privilege science and marginalise all other forms of practice (Apker & Eggly, 2004), creating a distinct group of medical scientists, the boundaries of which are demarcated through the use of technical language, or jargon (Wodak, 1996). Authors such as Wodak and Erickson, have explored some of the means by

which doctors assert and reaffirm their belonging to the group, for example through rituals of talk such as grumbling and moaning (Wodak, 1996), and through the use of linguistic devices such as ellipsis when elaboration seems warranted, or alternating between formal scientific and casual speech (Erickson, 1999). Erickson notes also some more dangerous markers of belonging, including the denigration of patients' conditions as 'medically uninteresting'.

The defensive nature of collegiality

A number of authors have suggested that the collective medical identity developed as a defensive response to doctors' shared sense of vulnerability to error and potential criticism, noting that doctors enter the world of medical work as part of a 'protective cohort', within which they remain, and that provides them both with a sense of belonging and with protection from potential criticism (Mizrahi, 1986). However, in the very midst of this 'protective cohort', there exists the potential for the growth of self-doubt within the individual doctor. Between the objective certainty of the group point of view and the individual doctor's attempts to manage inevitable uncertainty within the medical consultation, there exists the potential for strain. The uncertainties of the consultation demand that the individual doctor exert ethical discretion, bringing his personal subjectivity into view, and at the same time rendering him the observer and judge of his own performance (Armstrong, 2002). Other authors perhaps allude to the same phenomenon in their discussion, for example, of the 'twin pillars of medical culture' (Rosenthal, 1999: p. 150), namely medical collegiality and medical uncertainty, arguing that these produce both the need and the means for adoption of a highly defensive position. The continuous presence of uncertainty and fallibility mean that doctors share a powerful sense of vulnerability (Rosenthal, 1995). In her interviews with doctors, Rosenthal (1995: p. 20) reveals the frequency with which they make statements in respect of the errors of others such as "that could happen to me," and "there but for the grace of God go I." She argues that this shared sense of vulnerability reinforces doctors' mutual identification with one another, producing what she terms a "powerful mix of blame...and professional leniency" (1999: p. 162), in terms of which explanations are sought in the patient or anywhere else outside of the profession when things go wrong.

Collegiality and accountability

Particularly relevant to the arguments proposed in this thesis is the relationship identified by Mizrahi, Fox and Rosenthal between group solidarity, or collegiality, and accountability. According to Fox (1989), the existence of the collective medical identity is amongst those factors contributing to the belief that doctors alone are qualified to evaluate and regulate their activities, a belief that has resulted in the establishment of autonomy of the medical profession, as discussed above, and hence its relative immunity to external attempts at critical evaluation and regulation. Within the professional group too, individual doctors are discouraged from facing the consequences of, and accepting responsibility for, questionable actions. Not only does membership of the collectivity enable individual doctors to avoid experiencing responsibility for unfortunate actions as specifically their own (Mizrahi, 1986), but the norm of non-criticism discourages doctors from voicing or even inwardly acknowledging the occurrence of erroneous or otherwise questionable events. As Millman (1977) points out, as soon as one doctor calls attention to his own or to the errors of another, or admits to a feeling of guilt, the fallibility of the entire institution of medicine and of all its members is made visible. Instead, medical students are carefully taught not to recognise as error what the outside world would, and medical routines such as case reviews are not so much intended to reveal the truth about what actually happened, as designed to restore the image of the meticulous practitioner and to disguise the carelessness of unfortunate actions.

According to Paget (1988), not only do the rules of professional etiquette forbid the expression of criticism of a colleague but even the assumption of a critical attitude. Paget argues that the prevalence of this norm both unites doctors defensively against the lay community and, at the same time, allows individual doctors a maximum level of independence and autonomy, the combination rendering the medical profession a “delinquent community” in which etiquette is prioritised over accountability. Hence, knowledge of poor practice remains unrecognised within a closed community, resulting, according to Alsop and Mulcahy (1999), in a failure of the medical profession to appreciate the concerns of its patients or even their right to be heard. Poor practice remains unaddressed and the collective understandings that enabled its occurrence are reinforced, free from the intrusion of competing discourses. In addition, these authors argue that exclusion of non-members, including hospital management, from information about complaints or other indicators of the

possible occurrence of poor practice means that the pathways leading to its taking place are never examined and both learning and risk management are, in the process, inhibited.

‘Us and them’

As Zagier-Roberts (1994) points out, the identity of any group always includes a dimension of being alternative to some other group. In the case of the identity of doctors, authors such as Rothman (2003) and DelVecchio-Good and Good (2000) have pointed out that the ‘iron curtain’ that exists between doctors and patients has been erected in part through the profession’s historical development, leaving doctors isolated in a world of disease and death (Rothman, 2003).

In the years after 1945, the house call disappeared as the doctor’s primary means of accessing his patients and was replaced by the current system, within which patients visit their doctors in unfamiliar medical surrounds, isolated from their lived environments, their personal contexts hidden from the doctor’s view (Rothman, 2003). This situation, Rothman points out, has produced a real gap between doctors and patients, compounding the effects of the symbolic one and resulting in a situation in which, by the 1960s, few people could be expected to remember the last time they met their doctors with their clothes on! In addition to the disappearance of the house call, the ever-increasing trend toward specialisation within the medical profession has meant that the majority of doctors are trained in the functioning of one specific part of the human body, increasing their tendency to lose sight of the whole person to which that part belongs. This, in addition to the increasing emphasis on technological medicine and the external pressures placed on doctors’ time, has resulted in a view of “linger(ing) at the (patient’s) bedside” (Rothman, 2003: p. 131) as a luxury in which few doctors can afford to indulge (DelVecchio-Good & Good, 2000).

Katz (1984) and Dreyer and Geist (1993) have highlighted the opposing constructions that dominate the characterisation of doctors’ and patients’ identities within medical culture, arguing that these revolve around constructions of doctors as entirely rational and patients as utterly irrational. Both Katz and Zagier-Roberts (1994) have pointed to the defensive nature and function of these polarisations, suggesting that doctors project their irrationalities onto their patients in what Katz (1984: p. 150) calls “one of the most pervasive and fateful countertransference reactions.” Thus, the medical world is characterised by what Fisher

(1986) refers to as a 'two-place logic', in terms of which people are defined as 'doctor' or 'not doctor'.

As Fox (1989) points out, within the world of the hospital, the distinction is not merely a conceptual one. Rather, it is enacted and made real by its participants, groups of doctors and patients coexisting and interacting with one another but their experiences remaining altogether separate. This social distance between groups is not merely brought into being through the actions of individuals who perceive themselves as different from one another but is in fact formally prescribed. According to Goffman (1961), within 'total institutions', of which the hospital is one, the flow of communication between groups is restricted, in particular with regard to the flow of information. This restriction manifests inevitably in the familiar situation in which doctors withhold information from their patients about the plans that they have for them. Even talk between the groups may be conducted in a special tone of voice, reserved for interactions across boundaries. In another landmark publication by Ruth Wodak in 1996, entitled, 'Disorders of discourse,' this author details the linguistic means by which understanding between groups - in particular patients' understanding of doctors - is obfuscated by the use of jargon, acronyms and complex sentence constructions. As Wodak points out, the technical jargon used by members of the medical profession serves not only to construct doctors' identities but simultaneously produces an opposing marginalised group, namely patients, whose talk is worth much less than that of doctors and who are unable to understand their doctors' speech. The result, Wodak argues, is misunderstanding between mutually distinct 'cognitive worlds' and a situation that she terms 'frame-conflict', and that involves the collision of separate worlds of knowledge. This collision, she notes, has a predictable outcome, namely the dominance of that group most linguistically competent within the setting.

In the more recent work of Maynard (2003) and Andersen (2004), as well as that of Mizrahi (1986), these authors have discussed the potential effects on care of the rigid distinction between groups in hospital contexts. Maynard explores the increased likelihood that doctors will be non-empathetic toward patients who are more dissimilar from themselves, frequently displaying 'cold' and 'heartless' behaviour toward those whose socio-economic backgrounds are markedly different from their own. Offering an explanation of this finding, Andersen argues that indifference and discrimination tend to be perceived as more justifiable when

directed toward members of an out-group. This allegation is well illustrated in Mizrahi's 1986 study in which she quotes a doctor as explaining that "you're allowed to disparage patients and to objectify them and to care less about them as people...when you turn them into something other than human..." (p. 34), implying the importance of identification in applying the norm of good treatment.

Labelling patients

Not only is it argued that doctors and patients differentiate themselves rigidly from one another but also that they conceive of each other in terms of hostile stereotypes. As early as 1961, Irving Goffman, in "Asylums," described the staff in what he termed 'total institutions' as tending to see the inmates as bitter, untrustworthy and secretive, and they, as seen in turn by the inmates, as mean, high-handed and condescending. Such stereotypes have nevertheless been found to reflect feelings of anger and hostility and to be associated with the delivery of less compassionate care (Mizrahi, 1986).

Amongst the more frequently discussed labels applied to patients are those attributed to 'problem' patients who in one way or another fail to conform to the expectations held of 'good' patients. While 'good' patients cooperate unquestioningly with hospital staff, allowing medical routines to continue uninterrupted, 'problem' patients violate these norms and fall short of the values dear to the medical relationship (Fisher & Groce, 1985). Murcott's (1981) argument that such categorisations aim merely to improve the efficient functioning of hospital staff appears thin in the face of the number of instances in which social distance has been shown to be associated with classification of patients as 'bad' (Fisher & Groce, 1985; Strong & Davis, 1978).

Other authors, such as Mizrahi, have argued that not only those patients who violate accepted medical norms, are from different socio-economic backgrounds than their doctors or are identified as derelicts, drunks or otherwise morally reprehensible, are labelled as 'bad'. Mizrahi (1986) argues for a situation in which *all* patients are 'damned if they do and damned if they don't', either seeking medical help too early or for too minor concerns, and thus establishing themselves as 'system abusers', or attending to their ailments too late and thus fixing their identities as 'self-abusers'. In both instances, these identities render the relevant patients less worthy of care and are associated with avoidant behaviour on the part of the

relevant professional. Disturbingly, Mizrahi (1986) found that two thirds of the house staffers in her study admitted differential treatment of pejoratively labelled patients, a figure that rose to three quarters when differential treatment was defined to include acts of omission. The characterisation of patients in terms of disempowering traits justifies their marginalisation, obviating, for example, the need for informative communication with people who are too ignorant or otherwise incompetent to participate effectively in the medical relationship. Such characterisation, says Millman (1977: p. 202), “is the prime justification for the profession’s inclination to make the client at best a passive participant in the work – to, in essence, remove from the client his everyday status as an adult citizen, to minimise his essential capacity to reason and his right to dignity.” Not only is the quality of care administered to ‘bad’ patients thus inferior by the doctors’ own standards but the very existence of labels deprives patients of their dignity and in itself, Atkinson (1995) argues, represents the “utmost abuse of professionals’ discursive power” (p. 33). The asymmetry in the relationship, he continues, is such that the consultation’s overtly benign purpose is overridden by a situation in which the patient is transformed from the interaction’s beneficiary into its victim.

Medical culture, identity, self-doubt and defences

A number of authors (Fox, 1957; Mizrahi, 1986; Katz, 1984; Cassell, 1992; and Zagier-Roberts, 1994) have argued that the above features of medical culture, along with the associated construction of the identities of both doctors and patients, produce conflict and self-doubt in the management of doctors’ identities, and frequently result in their assumption of defensive attitudes and strategies, with potentially harmful consequences. Authors including Freidson (1970) and Speck (1994) have argued that traditional medical understandings, in terms of which the all-powerful doctor literally holds the patient’s life in his hands, lead to the contingent belief that doctors are necessarily to blame for poor outcomes of care. In these terms, doctors tend to perceive and experience even seemingly inevitable deaths as indicators of failure (Mizrahi, 1986). Obholzer (1994) suggests that this perception stems from the unspoken collusion in which both doctors and patients are motivated to maintain the belief that good medical care prevents illness and death in their joint effort to protect patients from their fears of dying and doctors from the anxiety engendered by recognition of their fallibility. Obholzer (1994: p. 174), echoing the earlier comments of Paget (1988), further argues that, on the contrary, “a great deal of what goes on (in the hospital) is not about dramatic rescue but rather about facing one’s relative

helplessness in the face of illness and death.” The lack of preparation in medical education and socialisation for this reality, he argues, accounts for much of the low morale and high turnover observable amongst doctors and other hospital staff. And Zagier-Roberts (1994) notes that one of the primary features of care work is that it is the carer’s self that is seen as the instrument. Thus, medical failure is equated with failure of the self and can produce doubts that endanger the maintenance of doctors’ positive self-identity.

A very little explored area, these constructions set doctors up to grapple endlessly with issues of culpability and responsibility (Mizrahi, 1984), a pastime that Mizrahi, amongst others, including Dreyer and Geist (1993) and Andersen (2004), have shown to be fraught with evidence of avoidance. Atkinson (2004) discusses extensively the attribution of responsibility in talk between doctors, as they establish their own competence in discussing patients and the evidential bases of their assessments. As discussed by a number of authors, including Good and DelVecchio-Good, Dartington, Oberholzer, Mizrahi, Mishler and Goffman, amongst others, doctors’ deep fear of failure can provoke defensive reactions. As these authors point out, there are a whole variety of compelling reasons why doctors are particularly prone to the development of defensive coping mechanisms. In addition to the constructions prevalent in medical culture and to the formation of doctors’ identities in tandem with these, doctors are trained under immense pressure, including long hours, sleep deprivation, overwhelming workload and extreme pressure to perform (Mizrahi, 1984; 1986). Combined with the powerlessness they experience to reverse many disease processes, these pressures are highly conducive to the development of defensive strategies (Mizrahi, 1986). Medical culture also makes no allowance for doctors to process their emotional responses to what are often deeply distressing or horrific events. Rather than training or otherwise assisting doctors to cope with their experiences, events such as death are medicalised, addressed only in technical terms and their affective dimensions obliterated from view (Good & DelVecchio-Good, 2000).

Some healthy defences are certainly in order if doctors are to protect themselves from stress in order to continue the work task (Dartington, 1994; Cohn, 1994) and to maintain emotional balance so as to be able to function effectively in their work roles (Coombs and Goldman, 1973). And overwhelming numbers of cases sometimes necessitate that doctors narrow the scope of their interactions with their patients in order to be able to attend to all of them (Mizrahi, 1986). However, these and other authors have argued that in many instances, the

defences that doctors develop in order to cope with their situations are in fact maladaptive. While the process whereby doctors become hardened to horror and to the suffering of their patients has been referred to as one of 'settling in', Obholzer, arguing for its pathological nature, calls it instead a "flight from reality" (p. 174). Mizrahi (1986) and Dartington (1994) argue that many of doctors' defences produce negative consequences, for example indifference, or, in extreme cases, 'manic denial', a defensive response in terms of which doctors manufacture excitement in order to obliterate despair (Dartington, 1994).

The notion of 'detached concern' provides a good example of the potential for healthy coping mechanisms to become maladaptive defences. In the first years of medical training, students are taught to develop detachment so as to assist them in coping with their feelings of helplessness and vulnerability when exposed to distressing realities. Later in the curriculum, they are encouraged to develop concern, the intended outcome being a stance of 'detached concern' from where doctors are able to offer empathic but nevertheless objective treatment to their patients (Mishler et al., 1981). However, what can and all too frequently does happen is that doctors become overdetached, no longer able to empathise with their patients and indifferent to, rather than somewhat distanced from, their suffering (Mishler et al., 1981). In Mizrahi's (1986) study, such overdetachment is shown to foster the GROU approach to patient care.

One of the key elements of these defences is that they are not just theorized as individual responses to emotionally distressing circumstances but are perceived as features of the medical culture, arising from shared feelings of guilt and responsibility (Mizrahi, 1984). As Mizrahi points out, the inevitability of error is so pervasive in medical practice that those who do not believe that they have killed a patient by the end of their medical training are considered lucky. Thus, medical culture makes available a repertoire of means for dealing with distress and for avoiding responsibility, comprising, for example, of commonly held beliefs such as, 'everyone makes mistakes,' designed to help doctors cope with the sometimes horrific, unintended consequences of their actions. Medical culture does not encourage emotional responses to events, as these represent threats to the whole system (Dartington, 1994). Instead, senior doctors effectively say to junior ones, "This is how we ignore what is going on. Pretend along with us and soon you will be one of us" (Obholzer, 1994: p. 174). Thus, through examples set by senior doctors, as well as through the pressure

exerted by the peer group in the form, for example, of humour or ridicule, doctors are socialised into culturally prescribed ways of responding to events (Hafferty, 1991).

Blame is the most frequently mentioned avoidance mechanism and the shared understandings invoked to justify what might otherwise be viewed as bad practice generally include externalisation of responsibility onto an object or other, such as the bureaucracy, a subordinate or the disease, that is beyond the relevant doctors' control (Mizrahi, 1984; Wodak, 2006b). Blame represents the all-time justification for poor delivery of care, for patients' mistreatment and for their doctors' acquittal, anchoring the cause of problematic events outside of the relevant organisation, and transforming the patient into the hospital's or doctors' ultimate enemy, against whom they need to be defended. Mizrahi (1986; 1984), Paget (1988) and Zagier-Roberts (1994) explore and illustrate the relationship between blame and bad practice, arguing, in essence, that "blaming the other...sets the other apart," and that "the apartness of the other is like the apartness of the self who has disowned his own faults" (Paget, 1988: p. 154). As the ultimate 'other' and prime targets for this externalised responsibility, patients are thus 'discredited' (Mishler et al., 1981), blamed for their doctors' failings, for being sick in the first place and for not getting better. Hostility and aggression on the part of doctors are experienced as originating, not from themselves, but from external sources; and the tables are turned, doctors experiencing persecution by their patients (Zagier-Roberts, 1994). Both aggressive acts and errors can therefore be pinned on patients, who are perceived as having failed to reveal the information required for accurate diagnosis, as 'poor historians' or even as having intentionally deceived their doctors (Mizrahi, 1984). Mizrahi thus describes a "world of contradictions wherein the patient (is) oppressed while being characterised as the oppressor" (p. 35). Patients, despised as abusers, are thus subjected to abuse, shunned by their doctors, given perfunctory care or, for example, resuscitated without vigour (Mizrahi, 1986).

In combination with the status of object that is ascribed to patients, encouraging doctors to disidentify rather than empathise with their patients, Szasz and Hollender (1997) have argued that blame increases the likelihood that doctors will subject their patients to inferior treatment, as they are transformed not only into enemies but into enemies devoid of their human nature. Lorber (1975) has documented the kinds of treatment that these negatively intoned interactions can produce, arguing that these include acts and omissions that constitute

punishment and neglect.

Other defences discussed in the literature include denial, in terms of which doctors are alleged to avoid feelings of guilt, anxiety and grief for any damage the patient might have suffered as a result of their ministrations (Zagier-Roberts, 1994), or in terms of which they negate concepts such as that of error, in order to redefine questionable actions on their part as, for example, judgement calls within 'grey areas' of medical practice (Mizrahi, 1986). Related defences, such as repression, may enable doctors to actually forget what really happened, remembering instead a less threatening version of events. Such means of dealing with affective responses such as anxiety and guilt have huge implications for accountability, especially when they occur within the context of collegiality that characterises medical culture. Iedema (2007) analyses what he refers to as critical incident reports, in which doctors narrate instances of medical failure in which they have been involved. Exploring such aspects of these narratives as the use of the passive voice to describe erroneous actions, euphemistic references to death and the structure of the texts, Iedema shows how some of the authors of these texts respond defensively to the task of narrating failure and make use of these constructions to diminish the serious nature of the relevant errors. Also employed are devices involving the attribution of responsibility, and depersonalisation of responses, with potential consequences for the management of clinical activities and associated risks. Mizrahi (1986) argues that even in instances in which neglect or harm do not result from the adoption of these defences, the dehumanising climate that they create is uncondusive to harmonious relationships between doctors and patients (Mizrahi, 1986) and can create feelings of estrangement and abandonment in patients (Katz, 1984).

Summary

In this chapter I have addressed representations of the construction of identity in the literature on medical culture, attempting to integrate themes exploring the collective nature of medical identity with those investigating the relationship between collegiality and accountability. Through articulating this relationship I have attempted to highlight linkages between these aspects of medical culture and the possibility for poor medical practice. I have explored the association of this collective identity with the binary construction of doctors and patients, resulting in the potential for hostile and discriminatory treatment, a potential that is enhanced by the psychic defences shown in the literature to be engendered by these aspects of medical

culture, contributing to the possibility of over-detachment, avoidance of responsibility and distressing emotion, and patient blame, with associated consequences for the delivery of care.

CHAPTER FOUR

POWER IN MEDICAL PRACTICE

The power of the medical profession is multi-dimensional and multi-layered, existing at all levels of the professional body, from its institutional structure and relationship with the rest of society, to the minutiae of its members' interactions with their patients in medical encounters. This chapter sets out to review discussions of power within the literature on medical practice, with a particular view to articulating the relationship between themes arising in these discussions and the possibility for abusive practice and delivery of inhumane care. As in the previous chapters, these links are sometimes made explicit by the authors themselves and at other times not. Interrelationships between the various themes discussed under this broad construct are represented in this body of work only to the extent that the different authors are responsive to one another's work. My aim in this chapter is once again, therefore, to establish the linkages between the sometimes disparately appearing themes in discussions of medical power and between these and violations of medical ethical standards and of patients' rights.

Discussions of power in medicine largely parallel those of culture and identity in medical practice. This is partly because these issues are closely interrelated in the literature, frequently appearing as part and parcel of the same discussions by the same authors. The reader will note that many of those authors whose work is most prominent in the previous chapters occupy the same position in this chapter. The separation of the three themes in this review is thus somewhat artificial and serves my purpose of attempting to organise a complex mass of material, rather than representing distinct bodies of work. However, there are also distinctions between the areas of discussion, although not in the work of every author. Some authors deal only with issues of medical culture and or identity, ignoring the matter of power. These authors appear in the previous chapters but will not be included in this chapter. Others tackle the issue of power explicitly and with little reference to other features of medical culture or the identities that emerge within it. Their work appears in this chapter but not in the others. From my point of view, the relationship between issues of medical culture, identity and power can most usefully be construed as reciprocally related. Each informs and enables the others in such a way that none can be adequately understood without reference to the

others. This relationship will be evident throughout this chapter, as discussions of medical power cohere around key themes in those of medical culture and identity and vice versa. The core distinction between the three chapters, then, is that the first highlights in discussions of medical practice themes that can be classified as describing elements of medical culture; the second highlights in these same discussions themes that can be classified as describing the identities that emerge within medical culture; and the current chapter lifts out, again often from the same material, those themes that can be characterised as primarily addressing the issue of medical power.

The institutional power of medicine

The power held by the medical profession as an institution is the first theme that I will address in this chapter. As is the case with respect to the relationship between medical culture, identity and power, that between the institutional power of the medical profession and the manifestation and enactment of power at the interpersonal level is reciprocal. Any separation of the two areas of discussion thus represents a conceptual distinction, intended to clarify concepts and assist in effective organisation of the relevant material, rather than to imply their independent functioning. Having said that, there is, however, a more clear-cut distinction in the literature dealing with medical power between those authors who address the issue at the institutional level and those whose focus is more attuned to the operation of power at the interpersonal level. Rather than driven by a conviction that the two aspects of power exist independently of one another, however, this division seems to arise from the theoretical backgrounds of the relevant authors, which channel their focus toward either the macro or micro dimensions of social reality. As will be discussed in the course of this chapter, there are also those authors who, more in keeping with my own theoretical orientation, which will become more evident as I address their work, highlight the relationship between the two levels. As my chief concern is with abuse of patients by doctors and delivery of inhumane care, which, while occurring in a reciprocal relationship to the institutional context, are manifest at the interpersonal level, I will address those aspects of the discussion of medical power within the literature that are limited to a concern with the institutional dimension only relatively briefly.

Theoretical approaches to institutional power

Those authors who have addressed the institutional power held by the medical profession

have done so from various theoretical perspectives. Since the focus in this thesis is on tracing pathways through which imbalanced power contributes to inhumane and abusive practices, theoretical discussion of the nature and concept of power is outside of its scope. Suffice to say that, while very few authors make their theoretical stance explicit, the variety of perspectives has led to substantive differences in the ways in which these authors have approached the issue of the institutional power of medicine. Functionalist perspectives, predominant in the literature prior to the 1970's, conceptualise power as the inevitable and necessary outcome of expert knowledge. Headed up by Talcott Parsons, this viewpoint has, to a very large extent, been shouted down by approaches more critical of medical power, led early on by the sociologist, Eliot Freidson (1970a; 1970b; 1975). A modified functionalist approach does, however, continue to inform the work of certain authors in the field. While Parsons's original perspective denied the possibility for conflict between doctors and patients, and for the abuse of power by doctors (Turner, 1995), more recent writers who adopt a functionalist stance make allowance for these possibilities. David Silverman, for example, argues that the fact that doctors have greater medical knowledge than patients is necessary to the medical relationship and that a power imbalance is an unavoidable consequence of this fact. He acknowledges, however, that this power imbalance holds the potential for both positive and negative consequences. The very thing that enables doctors to successfully treat their patients, the powerful position that results from greater knowledge is also open to abuse. To ask of the medical profession that it relinquish its power would, however, be to ask that it dissolve itself altogether, a suggestion that would serve the interests of no one (Silverman, 1987).

Other approaches conceptualise power as the product of the relationship between the medical profession and lay society. Power, in these terms, is conceptualised by some authors as produced through a consensual relationship within which lay society willingly subordinates itself in the interests of a common goal, namely the prevention and cure of disease. Power is thus not inherent in superior knowledge but revolves around its use, and domination is perceived as legitimate (Cicourel, 1999). Other authors have opposed this benevolent construction of the workings of power within the medical profession, proposing that, rather than a consensual and mutually beneficial relationship between medicine and society, the relationship is a conflictual one, in terms of which each party struggles to achieve power and status. Medical dominance is the result of this struggle and is maintained through the

autonomous control exercised by the medical profession over its work (Lupton, 2003). In Foucauldian terms, knowledge and power are almost inseparable, networks of power producing knowledges, such as medical knowledge, which in turn further the power of some groups over others – in this case furthering the power of the medical profession over the lay public (Lupton, 2003). Constructionist approaches prioritise interpersonal interaction in the production of structural arrangements, exploring the moment-by-moment processes within which medical power is produced and reproduced between individuals. While I mention these here because they do represent an approach to understanding the institutional context of medical power, constructionist standpoints tend to direct authors' focus toward the micro-details of interpersonal interaction and will thus be addressed in that section of this chapter that deals with this aspect of the discussion.

Most in keeping with my own theoretical standpoint, and as detailed in the previous chapter, Fisher (1986) brings together structuralist and constructionist approaches in her 'contextual web metaphor', highlighting the reciprocal relationship between the "organisational and structural arrangements of society" and the "core of spoken interaction" (p. 18). Fisher's contextual web allows for both the very real influences of social structures and for the agency of the individual in his response to these, in particular contexts and in interaction with others. Thus, power is produced both by broad social structures and by individuals' responses to these and to each other within such structures.

Key elements of the medical profession's institutional power

Within the literature addressing the institutional power held by the medical profession, two key themes emerge as representing the basis of medical dominance – possession of esoteric knowledge and freedom from external control. The two are clearly interrelated as esoteric knowledge is precisely what frees the medical profession from outside evaluation, allowing the claim that only a member of the profession is competent to judge the practice of another. The two are clearly related also to key components of the discussion of medical culture, in which the construction of scientific knowledge as superior and issues of medical silence and non-accountability represent core dimensions. In this section I will attempt to synthesize threads that appear in the literature addressing these themes that have relevance for the aim of this thesis to provide insight into the occurrence of inhumane care and medical abuse.

Medical knowledge

At the core of almost every discussion of both the structural, or institutional, and interpersonal manifestations of medical power resides the issue of knowledge, and perhaps all other themes pertinent to this discussion are in one way or another related to it. The immense power generated by the possession of knowledge, and scientific knowledge in particular, is clearly articulated by Habermas, who characterises scientific knowledge as “ideology par excellence, precisely because it claims to be above – that is, objective and value neutral” (Habermas, cited in Waitzkin, 1989: p224). Whether medical knowledge is accepted as superior in nature and therefore inherently powerful, whether it is viewed as a resource to be controlled and used in the interests of control, or whether it is conceptualised as inseparable from the power relations and social interactions within which it is produced, and which it maintains, it is generally accepted that superior knowledge, or the claim to superior knowledge, is the cornerstone of medical power.

By virtue of its esoteric nature, medical knowledge, deemed incomprehensible to anyone outside of the profession, is under the sole control of medical professionals. In addition to the status that such knowledge confers on its keepers, the control of medical knowledge renders the lay public dependent on the medical profession for access to and interpretation of the relevant knowledge, maintaining the cycle of domination (Borges, 1986) and posing serious implications for the public’s ability to participate responsibly in their own treatment (Millman, 1977), or to evaluate the treatment provided to them by professionals. As Katz warns, “the esoteric knowledge excuse has been employed sweepingly in order to keep silent about the simplest as well as the most complex medical interventions” (1984: p. 92).

Not only esoteric in nature, medical knowledge, as scientific knowledge, has a very special status, as detailed in the previous chapter with reference to the superior status attributed to scientific knowledge over all other forms of knowledge. Through its claim to objectivity, scientific knowledge assumes direct access to absolute truth, differentiating itself from all other knowledge, which is acknowledged to be produced through a process of interpretation. In distinguishing itself thus from the personal and political interests associated with human interpretations, scientific knowledge simultaneously shields itself from any external evaluations of the ‘truths’ it reveals (Wicks, 1998). The “hallmark of masculine power” (Benjamin, as cited in Wicks, 1998: p 94), objectivity promotes the development of a

patriarchal relationship between the medical profession and lay society, one that allows further justification of medical non-disclosure under the guise of protecting patients and the public from truths that lend themselves, in these terms, to construction as possibly damaging to their health and well-being (Katz, 1984).

A further feature of scientific knowledge pertains to its supposed ability to predict and thereby control the natural world. In the words of Borges (1986: p. 27), this power renders scientific, and hence medical, knowledge “the archetype of domination.” And, Borges argues, “with the domination of nature follows the domination of man.” The promise of the eradication of disease afforded by this control places the medical profession at the pinnacle of society’s hope for salvation, conferring on them a monopoly over health (Katz, 1984) and, along with its claim to objectivity, giving medical knowledge a status that no one has the right to resist. The medical profession is thus granted the freedom to do anything, “including violating all social rules of modesty and decorum” (Arney & Bergen, 1984: p. 3), so long as its actions can be shown to be in the patient’s best interest. In conjunction with its esoteric nature, in terms of which it is impossible to disclose to anyone outside of the profession exactly what such medical actions are, or why they are necessary, the door is opened to the abuse of power and of those who seek medical help.

Again outlined in the previous chapter, some of the authors mentioned above, as well as a number of others, have argued that these attributes confer on medical knowledge a status that parallels that of religion. Foucault is amongst the key figures pointing to the parallel between science and religion, arguing that, with the rise of science, doctors came to fill the role previously performed by priests. This parallel has been persuasively argued to be more than merely metaphorical. With the universally desired ideal of health and postponement of death in mind, and with scientific knowledge at their disposal, doctors are able to formulate the rules for correct living (van der Geest, 2005). Science, and biomedicine in particular, thus becomes the canon of ultimate truth (Turner, 1995). Medical power lies, therefore, “in the capacity to speak to another who must listen silently if he wants to hear the truth spoken” (Arney & Bergen, 1984: p. 4). Medicine thus acquires a position of total authority over not only medical needs but, more broadly, the rules of healthy living for society in general and for individual patients in particular, who must accept medical judgments without question (Katz, 1984). Doctors, Katz argues, having thus established their access to the truth and their

ability to cure disease and prevent imminent death, become not just like priests but like gods, to whom we all turn for mercy in times of crisis - in the words of Hippocrates himself, “The gods are the real physicians” (Katz, 1984: p. 8). Thus, a highly exaggerated belief in the infallibility of medical knowledge, as science applied by the new gods, is constructed and, to maintain the professional identity, needs to be itself maintained.

Autonomy

Almost certainly the most influential writer in shaping this field, Eliot Freidson (1970a; 1970b; 1975) was amongst the first to address the issue of the autonomous control of the medical profession over its own regulation. The monopoly exercised by the medical profession over both access to and application of medical knowledge, renders the profession autonomous or self-regulating. As a self-regulating body, members of the medical profession, by virtue of their status as such and their presumed dedication to their patients' best interests, have sole authority to monitor their own and each other's practices (Freidson, 1975). Exercised indirectly through licensing and training requirements, this form of regulation is considered by those authors who discuss it to be less effective in practice than in theory, the vestige of so much authority in one group raising concerns about the effectiveness of regulatory measures, and about their susceptibility to the influences of the said group's interests (Freidson, 1970a; Millman, 1977).

While the crux of the medical profession's argument for independent regulation lies in its claim to esoteric knowledge that is objective and consequently neutral, Millman (1977) argues that it is in fact social, economic and political judgments and evaluations that determine the application of medical knowledge. Since such judgments are, theoretically, as accessible to the general public as they are to the medical profession, Millman (1977) argues that social and political power, rather than expertise, determines the doctor's ability to make them. Initially, during the nineteenth century, anyone could take up the practice of medicine, making use of violent measures to purge patients of their illnesses and employing very little, if any (by later standards), scientific knowledge (Fisher, 1986). Close connections between educated groups and, initially, kings and subsequently parliament and other legislative bodies, enabled these groups to support one another in their mutual pursuit of power and authority, setting the stage for the development of the current medical monopoly, in fact established before medical procedures became either sophisticated or safe (Katz, 1984).

Rather than driven by objective scientific knowledge, therefore, medical practice is shown to be guided by moral and inevitably self-interested decision-making. In short, Millman (1977: p. 201) argues that medical decisions are made on the basis of the “convenience, interests and limited perspectives of those who take them,” all under the guise of protection (Borges, 1986). As Millman (1977) notes, when doctors in an emergency room punish patients who present with conditions not deemed to be real emergencies, these actions are guided by the self-interested application of medical knowledge to protect their own and their group members' interests. And, as Fisher (1986) points out, it is generally accepted that young doctors practicing in teaching hospitals are motivated to perform procedures and treatments on less powerful patients for the learning opportunities that they provide, rather than for the benefit to the patients.

In the light of these arguments, the danger of ineffectiveness in the medical profession's self-regulatory measures seems all the greater. Wherever there is power, there is potential for abuse, and when the less powerful party is dependent on the more powerful one, as is the case in the relationship between the medical professional and society, all the more so. In the case of medicine these dangers are compounded by its esoteric status and protective guise, in terms of which it is assumed, on the one hand, that the profession's absolute authority is necessary and unavoidable and, on the other, that its altruism protects its patients from abuse (Katz, 1984). With what Borges (1986: p. 28) refers to as “the invincible ideology of 'service' and protection as its justification,” obscuring not just the incidence but the possibility of malpractice, the “potential for exploitation is enormous.”

The escalation of medical power has been argued by some authors (see, for example, Lewinsohn, 1998; Kelleher et al., 1994; Charles, Gafnia & Whelan, 1999; Lupton, 2003; Phillips, 1996; Scambler & Britten, 2001; and Hogarth & Marks, 1998), to have been slowed by a variety of factors including the advent of medical consumerism, which has returned some power to patients (Potter & McKinlay, 2005). While no doubt valid in claiming that neither individual doctors, nor the medical profession holds power to quite the extent that it used to, these arguments are of limited relevance to this thesis, which addresses and attempts to explain a situation in which power was actually abused. In the remainder of this chapter I will turn to discussions of the workings of power between individuals and the opportunities that they present for abuse.

Interpersonal dimensions of medical power

The workings of power in actual medical settings are complex and, for the most part, intangible, providing a rich area for investigation, and one that has been addressed thoroughly in the literature. In the words of Wicks (1998: p. 91),

“Power is ever-present within health care settings. It is evident in the way people walk, in the way they communicate, in who gets recognised as having a presence and who gets ignored. It is evident in the tone people use when they speak, whether loudly or softly, and whether or not their words receive answers.”

While the presence of power is manifestly obvious in medical settings, therefore, its basis, operations and effects are not always equally so.

In this section I will review those themes in the literature that pertain to the power imbalances between individual doctors and patients in medical encounters. As in the case of discussions of institutional power, many of the same themes in terms of which I have organised discussions of medical culture will structure those of the workings of medical power at the interpersonal level, highlighting the interrelatedness of these discussions and their inseparable nature in reality. This chapter therefore combines additional elements of the work of many of the authors discussed in the previous chapter with that of other authors whose focus is more narrowly on the enactment of power, arguing that the status of the profession and the elements of medical culture, as enacted within the imbalanced power relationships that characterise medical encounters, further enable inhumane practice and the violation of patients' rights.

Approaches to the operation of power at the interpersonal level

A great number of authors have discussed the power imbalances that result from the institutional and cultural settings discussed in the previous chapter, as they manifest in the interactions between individual doctors and patients. As in the case of the treatment of medical culture in the literature, the operation of power at the interpersonal level is addressed from a variety of theoretical viewpoints, the majority of which are also not made explicit by the relevant authors. Again, it is beyond the scope of this thesis to attempt an analysis of this work that would comprehensively capture all the theoretical standpoints adopted or

categorize every author accurately. However, in order to locate the discussion in the remainder of the chapter within its theoretical context, I will provide a very brief overview of the dominant approaches, offering a slightly more detailed account of those taken by the most influential authors.

Power, society and the individual

From a structuralist viewpoint, social action is conceptualised as the direct result of structural arrangements (Fisher, 1986), individuals merely performing the roles cast for them in the social organisation. Much of the Foucault-inspired literature, too, attributes greater influence to the discursive terrain that shapes social action than to the active choice and participation of individuals. In Foucauldian terms, individual doctors and patients collude in the enactment of social discourses, and the routine operations of medical practice, such as the examination, become the apparatuses of power, through which doctors and patients live out their respective parts (Lupton, 2003).

The weight in the body of literature that focuses on the interpersonal dimension of power in medical settings falls, however, within the constructionist camp, which has spawned a great number of investigations of the function of language practices in the production and workings of power in medical settings (Lupton, 2003). In these terms, power is conceptualised as enacted by individuals, who are able to resist or employ it to serve their own ends (Fisher, 1986). Rather than a relatively static phenomenon, determined by structures in the broad social arena, power becomes a dynamic relationship, negotiated and renegotiated by its participants (Lupton, 2003), who take up some and reject other subject positions offered by available discourses.

While in the writings of many authors, constructionist formulations exist in contrast to those produced from structuralist vantage points, Fisher (1986), amongst others, has proposed that power can be better understood making use of both viewpoints. She proposes that power resides in the interplay between the institutional and interpersonal dimensions of social life, each reflecting and reinforcing the other. Thus, doctors, in whom the authority of the state is vested, and who possess unequal knowledge, conferring additional power on them, animate and amplify, and in other cases minimise, these institutional forms of power through their individual actions. The mechanism through which this interplay between the macro and micro dimensions of social life occurs is well represented, Fisher (1986) argues, by the notion

of situated practices, a concept that articulates the manner in which the broader social context is brought to life within the ordinary language and practice of individuals engaged in particular settings. Thus, ideology is employed by individual doctors in the specific contexts of actual situations. More in keeping with my own theoretical standpoint, which I will elaborate in the chapter detailing the methodology informing this research, such an approach, while retaining its acknowledgement of individual agency, also gives credit to the opportunities and constraints imposed by structural aspects of the environment, including the discursive environment. The marriage of the two approaches better resists the temptation presented by a more narrowly constructionist view to cast those in power, and thus doctors in the context of this thesis, as purposeful oppressors, out to serve their own purposes in any way that they can. Rather, doctors, as well as patients, are subject to the workings of the structural elements of their environments, and they, too, have greater access to some discourses and associated actions and less access to others (Atkinson, 1995). This view thus allows for the possibility of resistance by individual doctors to established norms and expectations, but also for the possibility that such resistance may provoke serious consequences. Authors such as Mizrahi (1986) and Fox (1989) have also cautioned against simplistic characterisation of doctors as employers of medical discourses to suit their interests, arguing that they, too, are co-opted into adopting the norms and language of those in power, through a process of socialisation that begins with medical training.

Power as an interactional accomplishment

A number of authors, whose work I will review in this section, have, from a variety of different perspectives, highlighted the nature of the power imbalance between doctors and patients as an interactional accomplishment achieved by all parties to a given interaction. As Fisher (1986) points out, neither does this joint production and maintenance of the status quo, within a context in which neither doctors nor patients are free from the influence of 'the powers that be', represent an argument against the indisputable fact that doctors possess institutionally-given power that patients do not, nor does it deny the very real effects of this power, evident, for example, in the routinely stifled voices of patients in medical encounters. What it does suggest is that patients *can* fight against their own domination, and in fact that they sometimes do, and also that doctors can and sometimes do subvert their own positions of supreme authority. This latter, I believe, is the most important contribution of the work highlighting the interactional accomplishment of power. Its production through interaction foregrounds its dynamic, and therefore changeable, nature rendering every moment in the

doctor-patient interaction a moment in which not only domination but change can occur.

While the basic premise that power is an interactional accomplishment is recognised by many, the manner of this interaction is conceptualised in a number of different ways. Mishler (1984) conceptualises the interactional production and distribution of power between doctors and patients in terms of a battle between the voices of medicine and of the lifeworld, animated through their moment-to-moment interactions, as detailed in the previous chapter, and in terms of which the 'voice of the lifeworld' is suppressed in medical encounters. The dominance of the voice of medicine accounts for the fact that these conflictual interactions are generally deemed unremarkable and are viewed, by both doctors and patients alike, not as suppressive endeavours, but as routine clinical practice. As discussed in the previous chapter, this binary construction in terms of which medical dominance is seen as a battle between two voices only is rejected by authors such as Fisher (1991), Silverman (1987) and Wodak (1996; 2006a), who argue that multiple voices characterise the medical setting and conflicts between them are disguised by the imposition of myths by those in power, myths that institutional members are obliged to believe and that represent a version of reality that claims, and indeed demands, consensus but that in fact exists to obscure disagreement and to protect the interests of the powerful. For example, the belief that doctors possess superior knowledge and are infallible silences contrary points of view and obscures courses of action alternative to those proposed by doctors (Wodak, 2006a).

The conversation analytic approach

Much of the work by those authors who conceptualise power as an interactional accomplishment falls within the conversation-analytic genre. Work in this genre was particularly prominent in the 1980s and 1990s, during which time there was an upsurge in explorations of the accomplishment of medical dominance through conversational means in medical encounters. (For key works in this area see, for example, Fisher, 1980, 1984, 1986, 1991; Mishler et al., 1981; Mishler, 1984; Silverman, 1987; Fisher & Groce, 1990; West, 1984, 1990, West & Frankel, 1991; ten Have, 1991; Waitzkin, 1991) While some of these authors employ a strictly conversation-analytic methodology, with its associated limitations, as discussed in the previous chapter, authors such as Sue Fisher and Elliot Mishler, while employing some of the methods of conversation analysis, adopt an approach that goes well beyond the limitations of any given conversation.

These authors have made use of conversation analysis to explore the production and distribution of power within the interactions between doctors and patients. Through analysis of the details of talk, this body of work explores the production of domination in the details of verbal interaction. In particular, conversation analysis, through its attention to the minutiae of verbal interactions, is able to explore the implicit components of talk (Gill et al., 2001), often obscured by methods that make use of broader brush strokes. West (1990), for example, shows how the distribution of questions between doctors and patients in medical encounters, in terms of which doctors' questions grossly outnumber those of their patients, is not simply the consequence of doctors' efforts to suppress patients' contributions, but is also the product of patients' own hesitance to ask questions, evident, for example, in the frequency with which they stammer when asking a question, as well as in the infrequency of the questions that they ask. Thus, West argues, doctors and patients cannot be simply construed as villains or victims of the power imbalance, respectively. Rather, both actively contribute to the prevailing situation.

Fisher (1986), while perhaps employing a more eclectic approach to the analysis of talk than the majority of her conversation-analytic contemporaries, makes use of conversation analysis and the sequences within and through which talk is undertaken, to illustrate the importance of the distribution of opportunities for speech between conversational partners for the production of inequality, as well as the modes of domination and resistance employed by doctors and patients in their interactions. She displays the usefulness of this method in detailing the *means* that doctors and patients employ as they struggle for power, making use of such conversational manoeuvres as correction, comment on the interaction, 'back channeling' and overlap as they grapple for the floor. Not only are such techniques able to highlight the subtle means of domination and resistance employed by doctors and patients (Maynard, 2003) but they further offer the potential for advancing alternatives through their consequent ability to reveal conversational possibilities for symmetry in the ways in which relationships are mutually achieved (West, 1984).

Conversational mechanisms and evidence of power

In addition to the potential for transformation highlighted by that more general body of work that defines power as an interactional accomplishment, probably the most important contribution of the conversation analytic literature to the discussion of power is that it has rendered visible the often implicit mechanisms through which power is produced and

negotiated in medical settings. As Fisher and Groce (1990) argue, conversations can be seen as micro political events, their 'architecture' revealing the means of subordination and domination as they occur in the enactment of practical activities ostensibly aimed at the diagnosis and treatment of patients' conditions. As noted above, in her 1984 work, "Routine complications," West explores questions centered on the actual means employed in the enactment of the social roles adopted by doctors and patients within specific interactions. She explores how medical definitions are superimposed on lay ones through the organisation of talk and how power and control become integral to their relationships through the range of actions and interactions that occur within doctors and patients' encounters with one another.

Also in a relatively early contribution to this field, Mishler (1984) shows how doctors use the position made available to them within the structure of the medical interview to dominate their patients, controlling the sequence of turn-taking that occurs in conversation, as well as the topics discussed. This they achieve, he argues, through use of the basic structure of the traditional medical interview, in terms of which the doctor opens the interaction with a request or a question, assesses the patient's response and uses this assessment to close the conversational cycle. She then opens the subsequent cycle with a further request or question. In such a way, the doctor monopolises the initiation of topics and responds selectively to the patient's contributions. Discussed by a number of authors working in the area, Heritage and Maynard (2006) show further how this structure is used to control the extent to which a topic is allowed to develop and to which patients are allowed to respond, thus exerting a profound influence on the nature of any communication that follows. Dreyer and Geist (1993) similarly show how doctors employ the three-part structure to deny their patients the opportunity to tell their stories and to construct the meaning of whatever is under discussion such that it is consistent with medical knowledge. This three-part sequential structure, therefore, not only facilitates but also provides evidence for the domination of patients by their doctors in the details of their interactions (Fisher, 1986).

Many other authors have focused, in similar vein, on, for example, other means of topic dominance by doctors, including the use of record cards in the initiation of topics by doctors (Atkinson, 1981), the simultaneous monopolisation of topic initiation and withholding of information (Sarangi & Roberts, 1999), the uneven distribution of acceptances and rejections of accounts offered by doctors and their patients (Fisher & Groce, 1990) and even the

distribution of laughter and civilities (West, 1984). Fisher (1986), Heath (1992), West (1984), Boyd and Heritage (2006) and Heritage and Robinson (2006), amongst others, have discussed the opportunities and constraints afforded doctors and patients within the dominant interview structure, arguing that the only phase of the medical interview in which patients are allowed to voice their concerns in keeping with their own agendas, is what is often referred to as the 'problem-presentation' phase, during which patients are invited to describe their reasons for visiting the doctor. Also discussed above, Mishler (1984) and Fisher and Groce (1990) have argued that during all other phases of the medical interview its structure is designed to do the exact opposite, namely to inhibit the emergence of the patients' lifeworlds. Robinson (2006), amongst others, has argued that utterances perform social actions and thus that doctors' questions influence the ways in which patients can respond. West (2006), for example, shows how the closing sequences employed by doctors as they terminate the medical interview dissuade patients from bringing up additional concerns. And Boyd and Heritage (2006) show that the questions put by doctors themselves contain preferences and presumptions, inviting some responses from patients and discouraging others.

West (1984) goes beyond description of the apparatuses of power in medical conversations. She argues that conceptualisation of the medical interview as an opportunity within which doctors can deductively test hypotheses about their patients' conditions, in combination with the construction of diagnosis as a process that occurs inside the doctor's head, rather than between him and his patient, renders it logical that patient's questions should be viewed as interruptions and consequently 'dispreferred'. She argues further that the associated reluctance on the part of patients to question their doctors and the doctors' frequently suppressive responses to any contraventions of this norm account, in large part, for the god-like status that doctors acquire within these interactions, in which they are construed as, and indeed become, unquestionable. She goes on to conclude that not only does this arrangement have consequences for the manner of communication that can occur in the medical interview, but that this in turn has consequences for the outcomes of health care, leading, in some instances, when mishearings and misunderstandings remain unresolved, to misdiagnosis, mistreatment and charges of malpractice.

Agency

A concept that recurs throughout the literature addressing the production and distribution of power between doctors and patients is that of agency. While conversation analysis represents the dominant approach to the exploration of agency within doctor-patient interactions, it is by no means the only one and the literature that addresses this concept is diverse. The bulk, if not all, of the literature that explores the operation of power in the interactions between doctors and patients can be discussed with reference to this concept. However, only a few of the authors writing on this topic actually make use of the word and perhaps the only feature that the writings discussed in this section have in common is that they all, in one manner or another, deal with the power of doctors and patients to act within their relationships with one another. Agency thus represents an underlying theme evident in the work discussed in this chapter.

Defined as the power to act, agency is, I argue, a very useful concept for exploring this capacity in the relationships between doctors and patients. It is not prey to the same shortcomings that Atkinson (1981) points out with reference to the concept of decision-making in medical settings, which can be deceiving in that it assumes a bounded and discernible event within which either one or both parties comes to a decision about a treatment or other action. On the contrary, the concept of agency is sensitive to the potentially fragmentary and incremental nature of the decision-making process and to the possibility that there may be no particular, identifiable event within which a decision to act in a particular way is taken. It is also not restricted to use within a particular theoretical or methodological framework, or in the analysis of particular kinds of events, such as conversations. Such sensitivity is particularly important to the topic under discussion in this thesis due to its concern with the subtleties of power and its exercise, and with the mechanisms by which it is sometimes abused without ever being overtly or even consciously acknowledged.

The analysis of power is thus undertaken by a variety of different authors through multiple lenses. While the focus of this thesis is on the discursive dimensions of power and its employment, no discussion of the imbalance of power between doctors and patients can afford to avoid mention of the fact that this power imbalance stems not only from the stuff of discourse, ideology, social arrangements, language practices and so on. As Zaner (2000) puts it, the power in the relationship between doctors and patients in fact has an existential reality.

Doctors have the means, including the knowledge, skills and material resources, limited though they may be, to diagnose and treat patients' illnesses and patients do not. Their power resides, therefore, not merely in institutional bodies or in the dynamics of interpersonal interactions, or even in the interplay between the two, but in the actual physical prevention of death and alleviation of pain and suffering that is the doctor's primary task. Authors such as Katz (1984) and Fisher (1980), for example, note the salience of the organisational context in limiting patients' contributions and of their internal fears, which doctors regularly exploit, such as those of illness and death, in rendering them susceptible to silent cooperation.

As stated, the focus of this thesis is, however, on the discursive context of medical encounters and the vast majority of work that addresses power in interpersonal interactions does so through an investigation of the use of language in medical settings. In the remainder of this chapter, I will therefore trace themes that emerge in the discussion of the discursive dimensions of the power imbalance between doctors and patients that have relevance to an explanation of inhumane medical practice. While there is a body of work, within which Howard Waitzkin probably represents the key figure, that addresses the ideological content of doctor-patient interactions, in terms of which broader social structures are seen to play themselves out in medical encounters, with potentially harmful effects, I will not address this topic in this review. The harm with which these discussions deal is related to maintenance of an oppressive social order, rather than to inhumane or poor quality treatment that leaves the individual patient feeling abused or neglected, and is therefore not directly relevant to my focus.

Knowledge and agency

As indicated in my discussion in this and in chapter two, addressing medical culture and institutional power, the superior knowledge possessed by doctors occupies a key position in discussions of power imbalances in the interpersonal relationships between individual doctors and patients in medical encounters. Much of the literature that explores this phenomenon departs from the point of view that doctors and patients enter their relationships from positions of power and weakness, respectively, as defined by their access to knowledge. Not only are patients often frightened and in unfamiliar surroundings, but they are unable to comprehend much of the talk and other events that are happening around them. Doctors, on the other hand, are on their home turf – they understand and are even influential in how the

medical context operates, they are exceptionally well-versed in the production and interpretation of the language spoken, and they have the knowledge and skills required to address the given problems (Fisher, 1986). Greeting each other from these asymmetrical positions, individual doctors and patients then proceed (more often than not) to reproduce and enact them through the routine and mundane elements of their encounters. The lack of information traditionally provided to patients, along with the evasion of their questions and the deliberate use of medical jargon, for example, denies patients the resources required to contribute to the process of diagnosis and treatment (Phillips, 1996), perpetuating and reinforcing their disempowerment.

Also discussed in chapter two, Katz (1984) and others argue that this power derived from the doctor's possession of medical knowledge rests on the fallacy of its certainty. The power that doctors hold through possession of 'certain' medical knowledge is maintained, Katz argues, through individual doctors' poor communication practices, as they fail to provide adequate information and explanations, which would reveal uncertainties, to their patients. Instead, they encourage reliance on the commitment to trust and obedience captured in the maxim, "Obey your doctor and you start getting well" (Katz, 1984: p. 7), a maxim that reinforces doctors' power by encouraging silence on the their part and unquestioning compliance on the part of their patients.

Doctors are thus construed as collectors and analysers of (superior) information, which they must simply elicit from their patients, who make no active contribution to the process (Mishler, 1984). The capacity of the patient to make informed and reasoned decisions is thus denied and blind trust in the now god-like doctors the only readily available option. The nature of the doctor-patient relationship, as defined in these terms, both obstructs the possibility of shared decision-making between doctors and patients and imposes an infantile participatory role on patients, whose relative power is further reduced (Katz, 1984). Doctors and patients are thus construed as active and passive, respectively (Arney & Bergen, 1984). Sole keepers of the knowledge required to make informed decisions, doctors assume the position of actors and patients that of acted upon. Interestingly, the very words 'doctor' and 'patient' – and the related word 'passive' – are derived from the Latin words for 'teacher' and 'sufferer' or 'one who just puts up with it', indicating the status of these constructions as embedded in language itself (Oxford English Dictionary, 1971). Patients' agency is thus

denied, any actions that they do commit become *reactions* to stimuli produced by their doctors (Armstrong, 2002), and the possibility of acting *with* or *for* them is effectively obscured (Mizrahi, 1986). Such constructions render doctors' silence, and their demands for faith and obedience from their patients, logical and reasonable (Katz, 1984), undermining any potential for dialogue between them.

Silverman (1987) discusses this issue with respect to what he refers to as the "autonomy / responsibility couplet." While they may wish to acknowledge their patients' autonomy, doctors are simultaneously aware of their own responsibility for their patients' care. In these terms, doctors are justified, and indeed obliged, to undertake whatever actions they deem are for the patient's good. The extreme case of this relationship, which, as discussed in the previous chapter is ultimately transformed into one between subject and object, is illustrated by that between surgeons and their anaesthetised patients (Szasz & Hollender, 1997). The unequal distribution of agency between doctors and patients is, however, evident also in the routine activities performed between doctors and conscious, lucid patients. As Szasz and Hollender (1997) point out, the roles of doctors and patients as active and passive, respectively, may be entirely appropriate for certain instances of emergency treatment, for example when a patient is unconscious, delirious or severely injured, in which instances treatment takes place irrespective of the patient's contribution. It becomes, however, at once inappropriate as soon as the patient emerges from the coma, or other incapacitating condition, at which point an accompanying change in the doctor-patient relationship is essential to the doctor's continued ethical practice.

While Katz (1984) is careful to point out that the motives underlying doctors' operation in the above terms are, in the vast majority of cases, intended to ensure the patient's best interests, he notes also the potential that this situation creates for these ends to be employed in justifying an unmonitored range of means, including those such as deception, manipulation, threat and force, all employed for the patient's own good (Szasz & Hollender, 1997). While such means, Katz maintains, are not driven by malice, they represent doctors' concern with their patients' wellbeing but not with their liberty. Arguing that the sharing of decisions about medical care can enhance not only the patient's autonomy but can alleviate her suffering, Katz repeatedly notes the dedication of the majority of doctors to their patients' physical wellbeing, but their simultaneous inattention to their right and need to make informed

decisions.

The potential inherent in these constructions for harmful effects on the patient have been illustrated by a number of authors who have shown, for example, that the absence of dialogue means that patients' concerns are more often than not left unexplored, while continuing to represent a valuable and unused resource for understanding their medical problems (Heritage & Maynard, 2006; Scheeres, et al., 2008). Heath (1992) and Barry, Bradley, Britten, Stevenson and Barber (2000), in an investigation of patients' unvoiced agendas, point out that the implications of these omissions frequently extend beyond the consultation, not only as a result of the potentially major misunderstandings that they produce and that can lead to misdiagnosis and thereby inappropriate treatment, but through their effects on the likelihood that patients will follow their doctors' recommendations. And Slingsby (2004) notes that shared decision-making between doctors and patients has in fact been associated with improvements in treatment efficacy.

Just a little way further along the continuum, other authors, such as Wicks (1998), provide examples of the more brutal enactment of the unequal agency between doctors and patients, for example when doctors override their patients' objections to intrusive procedures, or simply fail to ask their permission to perform them. And Fainzang (2002) has shown that the unequal attribution of agency to doctors and patients serves to encourage and justify doctors' lies to their patients, which are told in order to serve their own ends. Such lies, often told for the patient's alleged 'protection' or to persuade him or her to comply with the doctor's aims, may result in patients' consent to procedures about which they lack information and, in some cases, even to unnecessary medical procedures, to which their consent represents not a reasoned decision but a response to their doctor's authority and their own incapacity (Fisher, 1986). Not only overt lies but the withholding of information falls into the same category, and authors such as Costello (2002) provide extreme examples such as those in which the patient is neither informed nor consulted with regard to the issuing of orders not to resuscitate him or her, should the need arise. Under such circumstances, implementation of the notion of informed consent becomes, as Katz (1984) puts it, a 'mirage', as doctors claim to support it but show no appreciation of the necessity for disclosure associated with it. Almost twenty-five years later, Kaja Finkler, in her 2008 discussion of the need for locally situated, as well as universally-oriented, bioethical frameworks, notes that it is common practice,

internationally, for doctors to employ the nominal practice of getting patients to sign lengthy consent forms of which the doctors are aware they have little understanding. While, as Millman observed in 1977, these acts of deceit are conducted ostensibly to protect patients from undesirable and unnecessary anxiety, they simultaneously serve doctors' interests, reinforcing their power within medical settings.

Authors such as Armstrong (2002) have argued that, since the years immediately after World War II, medical thinking has begun to acknowledge the volitional nature of the patient, whose behaviour has come to be seen as important to the process of illness prevention and management. Thus, according to Armstrong, patients are no longer construed merely as the objects of medical practice but rather have become more complex entities that are, simultaneously, its agents, choosing whether or not to follow their doctors' recommendations. As Luftey (2005) observes, many authors writing on such topics as promoting patients' compliance (see, for example, Stivers, 2006; Winefield, Murrell, & Clifford, 1995; Williams, McGregor, King, Nelson, & Glasgow, 2005; Schmaling, Blume, Afari, & Niloofar, 2001; Francis, Rollnick, McCambridge, Butler, Lane, & Hood, 2005; and Buller, Connell, & Spencer, 2005, amongst many others) have shifted to a terminology that characterises doctor-patient relationships as partnerships, rather than the more overtly paternalistically conceived 'parent-child' descriptions of the past. However, Luftey goes on to note that this shift in the language of description remains unmatched by actual practice, within which doctor-patient relationships retain much of their more authoritarian qualities associated with the past. No longer aimed explicitly at ensuring their patients' obedience, doctors' efforts are, in these terms, intended to elicit their compliance.

Agency and blame

Related to the construction of doctors as active agents and patients as the passive objects of their knowledge and practice, is the issue of responsibility, a topic that is highly relevant to this thesis but that is only touched on by a few authors (see for example, Katz, 1984; Fisher, 1984; Maynard, 2003; and Atkinson, 1995, 1999; 2004, who discusses the matter extensively with respect to doctors' attributions of responsibility within collegial discourse, for example to own or disown the production of a piece of evidence presented on a ward round). Maynard addresses the issue of the attribution of responsibility for good and bad events, referring, in particular, to the delivery of news in general, and to doctors' delivery of diagnostic news or

news related to the progress of illness or success of treatment. News delivery, he argues, invariably encompasses a moral dimension, raising the question of who is responsible for the good or bad event being reported. In this context, Maynard shows how people work to seek credit for the positive events they report and avoid blame for negative ones, denying or attributing responsibility to themselves accordingly. This issue is thus clearly related to the projection onto others discussed in the chapter on culture and identity in medical settings, in terms of which doctors blame patients for adverse events with respect to which they run the risk of being credited with responsibility, as sole agents within the discursive context. As Katz (1984) argues, doctors' denial of causal responsibility for adverse events necessitates their relinquishment of the sole agency they otherwise possess, through the employment of syntactically passive linguistic constructions, or through embellishments of their accounts that attribute blame elsewhere and deflect responsibility from themselves (Maynard, 2003). However, while not directly addressed by either of these authors, it may be a point worth noting with respect to the aim of this thesis to explore aspects of the medical context that precipitate abuse, that while doctors in these instances deny their agency, the reality is one of concealment, rather than actual avoidance. It remains the doctors who are dominant in making the attribution, and it is they who exercise the choice, successfully, in deciding who gets credited with the responsibility for which event.

While the mechanisms whereby agency is produced and distributed between doctors and patients are often subtle, its consequences for the processes and outcomes of healthcare can be serious, as detailed in the preceding chapter on culture and identity.

Patients' passivity

It is important to note that neither doctors nor the medical or broader context in which they work can be attributed with the sole responsibility for the medical dominance described, a point that I referred to briefly above with reference to the interactional production of power. In addition to some of the more 'objectively' discernible characteristics of doctors and patients, such as patients' illness and pain (Sasz & Hollender, 1997), which contribute to their passivity, and doctors' actual possession of the knowledge and resources required for the treatment of disease, which gives them an unarguable and indeed desirable power in their encounters with their patients, patients are argued by a number of authors to be complicit in the production of their own passivity. While doctors may exert effort in controlling their

patients, patients actively relinquish control to their doctors (Dreyer & Geist, 1993). Neither do patients compel their doctors to take their concerns seriously, nor do they interrupt them when they hog the floor (Gill, 1998) and it is they who render their own bodies, as objects, for medical examination and treatment (Heath, 2006). In fact, some doctors actually encourage their patients' participation to no avail, as they remain reticent despite invitations requesting their responses (Dreyer & Geist, 1993; Heath, 2006). Perakyla's (2002) study in a Finnish primary health care setting, showing that only one third of doctors' invitations were met with more than an acknowledgement from their patients, provides a useful illustration.

A number of authors have explored some of the reasons for this passivity on patients' part. Most obvious, perhaps, is the fact that patients are dependent on their doctors for such matters as the relief of pain and avoidance of death. Ehrenreich and Ehrenreich (as cited in Atkinson, 1995: p. 125) put the matter succinctly: "(The doctor-patient relationship) is a manifestly benevolent relationship: disobeying a teacher or boss might be seen as gutsy, but disobeying a doctor can only be construed as irrational." Authors such as Dreyer and Geist (1993) and Phillips (1996) argue that patients' perceptions of their doctors as busy, aloof and not wanting to be bothered by their concerns further mean that patients may feel that they cannot impose upon their doctors with, for example, unwanted questions.

In addition, Fisher (1984) and Fisher and Groce (1990) note that, as inhabitants of the same social world, doctors and patients share mutual understandings of their positions and both parties, by and large, act accordingly. These authors point out that not only treatment decisions but identities are in fact negotiated in medical encounters, and that doctors and patients, positioned differentially in terms of the institutional and broader social structures, have differential access to the interactional resources through which the construction of identities takes place. Thus, both doctors and patients act in accordance with the identities that they have negotiated for themselves and each other. Most notable here are the stereotypical constructions in terms of which patients are characterised, for example as ignorant, irrational, unintelligent and emotionally disturbed (Millman, 1977; Dreyer & Geist, 1993), traits that remove both their capacity and their right to dignity, justifying their objectification and obscuring their potential for agency. In the words of Dreyer and Geist (1993: p. 241), such constructions "mandate(s) that physicians lay down rules." These dynamics are exacerbated when broad socially structured differentials come into play,

exaggerating doctors' constructions of the difference between themselves and their patients, and thence between their own and their patients' logic (Dreyer & Geist, 1993), and leading to situations in which, as Fisher (1986) illustrates, poor women patients, for example, are denied even those choices commonly made available to their middle class or male counterparts and are consequently provided with inferior care. Patients who have had less access to resources such as education are even less inclined to challenge their doctors, or the above constructions of themselves (Atkinson, 1995).

Patients' resistance

As demonstrated by a large body of research from the 1960s onwards, the above mechanisms of domination, as employed by both doctors and by the patients themselves, have, by and large, "effectively inhibited all but the mildest rebellion on the patient's part" (Annandale & Hunt, 1998: p. 119). However, it has also been demonstrated that patients can and sometimes do resist and even challenge the power of their doctors. Gill and Maynard (2006), Strong and Davis (1978) and Katz (1984), amongst others, argue for the importance that both theorists on the subject and doctors themselves should acknowledge not only the tradition of domination of patients, but also their resourcefulness. In many instances patients can be seen to counter the authority of their doctors by exercising their own agency (Perakyla, 2006). Many authors, including Fisher (1984; 1986; 1991), Perakyla (2002, 2006), Atkinson (1995), Heath (1992) and Maynard (2003) offer examples of instances in which patients challenge their doctors or the passivity of the role traditionally ascribed to them as patients. There are multiple citations in the literature of instances in which patients ask questions, fight for the conversational floor (Fisher 1986), resist or take a stance with regard to their doctors' diagnoses (Maynard, 2003; Perakyla, 2002, 2006; Mishler, 2004), or attempt to neutralise the power of hospital staff by mocking senior doctors and making jokes between themselves (Zaman, 2004). In fact, Tanassi (2004) argues that in some instances, although patients may seem merely 'compliant', they are actually choosing to follow their doctors' recommendations because of their belief that they are suitable in the pursuit of their own goals – in the example Tanassi provides, fulfillment of their desire to become mothers.

While patients' agency thus should not be and has not been entirely overlooked in the literature, therefore, Fisher (1986) points out that their efforts at balancing the distribution of power frequently fail. Perakyla (2002; 2006) argues, perhaps for this reason, that instances of open disagreement are very rare and patients prefer to design their contributions to the

medical encounter in such a way as to avoid challenging or competing with their doctors' positions (Heath, 1992). As Mishler (2004) points out, patients are unarguably dependent on their doctors and, as a result, need to ensure that they receive the care they require. Thus, patients' expressions of agency tend to be in conjunction with simultaneous efforts to maintain the power differential in their doctors' favour, for example presenting their reasoning as subjective and approximate and avoiding addressing evidence supplied by their doctors, even when their contributions are intended to encourage the doctor to reconsider his point of view (Perakyla, 2002, 2006). While these tentative and indirect measures serve in part to reinforce the status quo, Fisher and Groce (1990) point out that in fact they are more likely to ensure that the relevant patient's concerns will be heard than might be the case were they to opt for more direct means of challenge.

Fisher and Groce (1990), Cicourel (1999), Fainzang (2002) and Zaman (2004), amongst others, note also, however, that not only do many challenges to medical authority occur in indirect ways but that many patients, unable even to tentatively suggest an alternative point of view or course of action, resort instead to alternative means of expression. For example, in the absence of the ability, or perceived ability, to initiate more direct challenges, some patients resort to means that may not be in their own interests (Fisher & Groce, 1990). Cicourel gives examples of instances in which patients obstruct communication, for example, offering inadequate replies or appearing to agree. He argues that these actions do not always result simply from the patients' inability to offer more extended contributions, but are sometimes intended to subvert a process by which the patient feels dominated and unable to otherwise resist. In such instances patients may refuse to follow their doctors' recommendations or may discontinue treatment, failing to return for continuation of their care. These acts of resistance take the form not of reasoned actions in keeping with specific disagreements with diagnoses or treatment plans but of more infantile means of resisting domination (Zaman, 2004). Other authors, including Wodak (2006a), Annandale and Hunt (1998), Katz (1984) and Ten Have (1991), have also linked patients' lack of cooperation, nonadherence to treatment recommendations and discontinuation of treatment to doctors' domination of their patients and patients' (real or perceived) inability to resist through other means. And Fainzang (2002), in her analysis of lying within the medical encounter, argues that doctors' lies, usually told in order to produce a behaviour in their patients, represent the exercise of power but that patients' lies are told in order to avoid their doctors' reprobation

and thus, rather than displaying their power, in fact confirm their lack thereof, representing a form of submission rather than resistance against an authority they dare not contradict. Such actions, obviously, can be detrimental to the treatment process, providing doctors with misinformation or concealing information necessary for accurate diagnosis and appropriate treatment.

The means through which patients may effectively exercise power have been debated in the literature. Mishler's construction of the battle between the voices of medicine and of the lifeworld implies that patients' power can be enhanced through assertion of the voice of the lifeworld. However, authors including Silverman (1987) and Fisher (1991) have challenged this suggestion, arguing that, "Patients cannot, as a call for a discourse of the social implies, speak the truth about themselves in authentic social voices and in so doing liberate themselves" (p. 176). While Fisher goes some way in agreeing with Silverman's point of view, namely that medical power might even be enhanced through introducing a 'discourse of the social' into its domain, thereby further expanding the reach of medical jurisdiction, she stops short of his argument that power is productive and that the problem is purely "one for the subject who acts" (p. 177). Fisher criticises this stance for its ultimate implication that if a patient's struggles against medical domination fail, this should be interpreted as indicating that the patient has not fought long enough or hard enough. Fisher wants, and I believe rightly, to maintain an acknowledgement of the strength of institutional power that lies at the root of medical dominance and that explains the failures of patients' most virulent struggles.

While this conversation, held initially between Fisher, Mishler, Silverman and Waitzkin, has not been pursued to resolution, partly because the relevant authors have either stopped publishing or diverged into less directly related lines of thought, Mishler's recent works (see Mishler 2004 and 2005) have perhaps resurrected the issue, and now pursue a line of thinking that echoes Waitzkin's earlier direction, proposing that in order to effectively challenge medical dominance doctors themselves need to become engaged in political action to address the social inequality that is responsible for much of the illnesses suffered by the poor. As I pointed out with reference to the work of Waitzkin, this line of argument exceeds the scope of this thesis, in that it extends far beyond the reaches of the perpetration of acts of abuse by individual doctors against individual patients, albeit located in and informed by a social context. Since the issue of patients' agency is such a relevant one, in light of the various

negative effects on quality and outcomes of health care proposed by those authors who have written on the subject, this conversation seems worth reestablishing.

Doctors' responses to patients' resistance

Whatever their form, patients' actions that deviate from the trust and obedience demanded by their doctors tend to be met with responses that reassert the power imbalance and the doctor's superior position. While 'put downs', rejections, blacklisting of patients amongst other doctors (Atkinson, 1995), interruptions, cut-offs and ignoring (Wodak, 2006a) are all reported to be everyday occurrences, and more often than not go without conscious apprehension on either the part of the patient or the doctor, the attribution of stigmatizing labels to patients who challenge the conventional order is sometimes associated with more serious consequences. Lorber (1975), Fisher and Groce (1985) Armstrong (2002) and Andersen (2004), for example, discuss the moral labelling of 'deviant' patients, who are characterised as 'defaulters' or as 'bad' or 'problem' patients. While the 'good' patient recognises her own ignorance and powerlessness, accepts the institutional procedures to which she is subjected without question, provides the necessary information, takes the required medication correctly and so on, those patients who do not accept the absolute authority of the medical staff, or who reject their doctors' monopoly over medical knowledge are characterised as 'bad' patients and are treated accordingly, sometimes in the form of verbal and even physical reprimand (Andersen, 2004). Lorber (1975), amongst others, provides examples of instances in which "problem patients" were tranquilised, discharged prematurely or referred for psychiatric treatment, arguing that, "the consequences of deliberate deviance in the general hospital can be neglect or a stigmatizing label, while conformity to good-patient norms is usually a return home with only a surgical scar."

Summary

I began this chapter by addressing those aspects of the literature that pertain to the institutional power held by the medical profession. Pulling together threads in the various discussions that address the characteristics attributed to medical knowledge, and showing how these place medical knowledge and practices beyond either question or scrutiny, I have attempted to articulate in this chapter the role that these characteristics play in establishing the powerful position held by the profession, disguising the social, economic and political

judgements and evaluations that inform application of medical knowledge, and creating the opportunity for inhumane or abusive practices to occur and to go unacknowledged.

I then reviewed in this chapter those themes in the literature relevant to the power imbalances between individual doctors and patients in medical encounters, articulating the relationship between these and key aspects of the medical profession's status and of medical culture, as described in the literature discussed in the previous chapters. The chapter has detailed those aspects of previous discussions that explore patients' domination by the medical profession, as well as their complicity and resistance. Pulling together themes from a diverse array of literature, the chapter has identified the doctor's possession of esoteric medical knowledge as a central point on which the play of power between doctors and patients hinges, highlighting the potential for unequal agency between doctor and patient to result in patients' diminished participation in their own care, as well as in patient blame, with potentially serious consequences.

The chapter goes on to review discussions in the existing literature of the ways in which patients may resist medical domination, noting also those threads in this discussion that indicate both the possibility for their failure, as well as for the 'distortions' of resistance that can occur within a context in which patients have limited power. These acts of resistance are shown to be not always in the patient's best interests and can lead, for example, to the patients' discontinuation of their own treatment or to their subjection to inferior care.

CHAPTER FIVE

PARTICULAR CONTEXTS AND INDIVIDUAL PARTICIPANTS

While the authors discussed in the previous three chapters have identified strands that run broadly through medical settings, some of these and others have also noted the importance of individual doctors acting within particular contexts in determining action, as well as in the production of valid interpretations of that action. Indeed, many of the studies that produced the picture of the medical world and its inhabitants represented in the preceding chapters placed considerable importance in their theoretical and methodological approaches on the internal worlds and or specific locales from which the doctors in their studies approached their patients. Much of this work has thus produced interpretations not only of medical culture in general but also of the interactions between the various features of medical culture and the diverse local contexts, as interpreted by the unique individuals who operate within them. This chapter thus represents another attempt to tease out discernible themes from an interwoven mass, rather than a review of a separate body of literature or discussion of concepts that are distinct from those discussed in the other chapters.

Medical culture and the individual doctor

A few authors have highlighted the importance of the individual doctor as the agent in medical settings, who is seen by authors such as Good and DelVecchio-Good (1993) as drawing on a diverse set of medical discourses in the mediation not only of institutional struggles but also of his own personal meanings. Studies exploring the internal worlds of individual doctors are relatively few. However, their contribution is nevertheless important in that it highlights the relevance of individual interpretation of cultural meanings as well as of individual agency in responding to these.

According to Armstrong (2002), there were no studies of the individual doctor prior to the 1960s and the turn of the investigative gaze on the doctor represents a change of revolutionary status. In the 1960s, researchers involved in the study of medical socialisation began to turn their attention to the formation of the doctor's identity as part of this process. These studies, while introducing the doctor as the subject of research, nevertheless portrayed

him in relatively uniform terms as the product of a universal medical culture. Only in the 1970s did the idiosyncratic self of the doctor emerge, and it was not until the 1990s that the doctor's body came into view as the ordinary and vulnerable body of any other. With the emergence of the doctor's body came the appearance of what Armstrong (p. 172) calls its "hidden baggage of self-interest and desire."

With the emergence of diversity between individual doctors (see for example Cassel's 1982 study of surgeons for an early example), and therefore the possibility of diverse styles of practice, came not only the development of a language of doctors' subjectivity but also a challenge to the supposition of objectivity in the practice of medicine (Armstrong, 2002). Authors such as Good and DelVecchio-Good (1993; 1995) began drawing attention to the role of doctors as creators, rather than merely readers or even interpreters of clinical narratives and the individual doctor's viewpoint became distinguishable from the collective medical view (Armstrong, 2002). This recognition of doctors' identity and experience further transformed the view of the medical encounter, which came to be seen, rather than in terms of an objective observer viewing a medical object, as an interplay between personalities, within which pathological processes could potentially occur (Armstrong, 2002).

The individual doctor's emotional response

The most prominent area of focus in those studies addressing the doctor as an individual is his emotional response. Authors such as Hahn (1985) and Speck (1994) have noted the less recognised emotions that frequently plague individual doctors, including a sense of guilt and powerlessness. And a number of authors, including Good and DelVecchio-Good (2000) and Hilfiker (1997) have discussed the failure of medical culture to provide the space within which doctors can process their emotions. Mishler, Back, Meier and Morrison, Lazare, Holman, Hilfiker and Speck, amongst others, have discussed the potentially negative effects of this omission on the quality of care that doctors provide. Mishler et al. (1981), with reference to a study by Grove, have described the potential for negative emotions such as hatred to result in doctors' unavailability and avoidance of their patients. Lazare (1987) refers to the shame and humiliation that doctors sometimes experience in their encounters with patients and has noted the tendency of some doctors to respond by engaging in 'counter humiliation' of their patients. And Back, Meier and Morrison (2001) have discussed the sense of powerlessness, grief, fear, guilt, insecurity and inadequacy that many doctors experience,

arguing that these emotions all too frequently lead to the relevant doctors' avoidance of their patients.

In particular, these authors argue that doctors' unacknowledged emotions are those most likely to lead to compromised care (Back et al., 2001; Holman, Meyer & Davenhill, 2006). Holman et al. and Speck (1994) provide examples of such instances, such as when doctors avoid dying patients rather than acknowledge their own responses to death (Holman et al., 2006) or when they engage in what Speck (1994: p. 96) refers to as 'hit and run tactics', which involve communicating an unfavourable piece of news, for example a patients' diagnosis or prognosis or a relative's death, in brusque and abrupt terms and then leaving as quickly as possible. With the potential for such consequences in mind, Katz (1984) argues that if doctors wish to carry out their professional responsibilities it is vital that they learn to manage their emotional reactions to distressing events such as death, pointing to the importance of self-reflection in medical practice.

The importance of particular contexts

Not only have the individual responses of particular doctors been recognised as important in determining the extent and manner in which meanings and power imbalances stemming from the broader medical culture and its institutional context are likely to be enacted. The importance of the local context in influencing and interpreting medical practices has also been acknowledged and has come further to the fore in the last few years. Hospital ethnography that focuses on the unique nature of particular medical settings is emerging as a growing domain of study (see for example Wind, 2008; Zaman, 2008, 2004; Finkler, 2004, 2008; Warren & Manderson, 2008; Kelly, Pearce and Mulhall, 2004; Scheeres et al., 2008; Andersen, 2004; Gibson, 2004; Tanassi, 2004; Vermeulen, 2004; and van Amstel and van der Geest, 2004). While not all of this work is relevant to the focus of this thesis, as the various ethnographic studies address a wide range of questions, some of which have little consequence for the occurrence of abuse and inhumane care, the approaches evident in the various works comprising the burst of ethnographic studies in medical settings in recent years signifies a developing interest in the relevance of the nuances of local contexts for the interpretation of medical practice. In her 2006a paper, "Medical discourse: doctor-patient communication," for example, Wodak specifically sets out to illustrate the importance of the immediate context to the interpretation and analysis of the details of medical encounters,

showing how the events of an entire morning are central to production of a valid interpretation of a snippet of conversation that took place on that morning, and of its meaning for the people involved.

The animation of discourse in particular settings

Fisher (1986) has employed the concept of situated practices, as elaborated in the chapter on power in medical settings, a concept that articulates the animation of elements of the broader social context, including discourses and other features of the cultural milieu, within the everyday practices in which people engage in particular settings. In terms of this notion, available discourses, ideological constructs, identities and so on, as well as opportunities and constraints made available by the structural features of the environment, are employed by individual doctors in the specific contexts of actual situations. While not always making use of the term, a number of authors writing in this field have made use of similar theoretical approaches to the one proposed by Fisher.

As Cicourel (1999) points out, such an approach is essential to answering questions concerning how people decide which norms or constructs are relevant in a given situation and it acknowledges individual agency as well as differences in subjective experience. A dual focus on the general trends in medical culture and context and on the specifics of actual settings and events thus allows movement beyond generic discourses and encompasses an understanding of people's everyday lives in interpreting their perspectives and actions (Halford & Leonard, 2006). In the words of Halford and Leonard, "Particular organisations are embedded in specific times and places. They have complex histories, spatialities and associated meanings. These different contexts offer multiple, fragmented and distinctive discourses on which individuals may...draw in the production of subjectivity." (p. 659) Thus, the categories of 'doctor' and 'patient', for example, specify general characteristics and parameters but can be performed differently in different situations, in keeping with available opportunities and constraints (Strong & Davis, 1978). Hospitals come to be seen, in these terms, as 'small societies', each with their own unique culture (Helman, 2001), in terms of which broader meanings are actualised in concrete situations (Mishler et al., 1981). These authors argue, therefore, that studies of biomedical practice should focus on the relationship between what DelVecchio-Good (1995) calls "local and international worlds of knowledge,

technology and practice” (p. 1) rather than on either one or the other.

Some authors, most notably Kaja Finkler (1991; 2008), have explored variations in medical practice in different broad cultural settings. For example, in Finkler’s case, in Mexico, as opposed to the United States. Finkler’s 2008 paper, “Can bioethics be global and local, or must it be both?” makes an argument for the need to incorporate into an ethical framework the lived experiences of the society in which it is to be implemented, if it is to be appropriate for the said context. While Finkler’s argument is most interesting in terms of a theoretical understanding of the importance of particular contexts both for the kind of action that can occur and for that which can be expected, those authors with whose work I am primarily concerned in this review, have dealt with more micro-scale environments, most especially within particular hospitals. For example, Cicourel (1987) has investigated the ways in which doctors and patients, pressured in particular directions by various social norms, negotiate their interaction within the context of particular settings. Mizrahi (1986) has shown how both external conditions and the particular organisational environment, including the policies and procedures in terms of which doctors are obliged to justify the length of each patient’s stay to federal bodies providing medical insurance, the magnitude of the workload, the shortage of available beds and the exploitation of house staff by hospitals, contribute to development of the ‘GROP’ approach amongst the doctors and interns in her study. Similarly, Dreyer and Geist (1993) have shown how the working conditions of hospital staff inform the delivery of health care, arguing that the conflict and potential for strain inherent in the expectation that doctors be the “unfailing gods of healing in a bureaucratised industry jammed with patients, bounded by insurance inflation, swarmed by epidemic diseases and urban breakdown” (Elliott, as cited in Dreyer & Geist, 1993: p. 237) influence their willingness to engage in dialogue with their patients.

More recently and more rarely, various studies have focused on the unique contexts of particular hospital units, for example intensive care units (Turnbull, Flabouris, & Iedema, 2005; Slade et al., 2008) and emergency departments (Scheeres, et al, 2008), both of which represent contexts with unique stresses and strains due to the high-risk nature of the conditions from which the patients are suffering and due to the unpredictable nature of the work.

While the focus in this review is on the content of the work that attempts to explain or has relevance for an understanding of inhumane or abusive medical practice, and not on the methodological means by which this information has been produced, it is worth noting the very wide variety of methods that have been employed to this end. The most commonly employed methods in this area include audio-recordings of doctor-patient interactions, interviews and participant observation. Most prominent, perhaps, in the context of explanations of inhumane or abusive practices are those studies that employ an ethnographic approach to studies of medical settings, making use of multiple methods to produce their findings. (See in this regard the work of authors including Coombs & Goldman, 1973; Hahn, 1985; Fisher, 1986; 1995; Mizrahi, 1986; Fox, 1989; Wicks, 1998; Atkinson (1995); Engeström, Brown, Engeström & Koistinen, 1990; Finkler, 1991; Halford & Leonard, 2006; and Moreira, 2004a, 2004b, 2004c). In the context of this review, and of the argument for the importance of the interplay between broader and specific settings, the major contribution of these ethnographic studies is that they have brought into focus the everyday routines and activities in which more general meanings are employed. These studies have thus highlighted the importance of the particular settings and individuals within which and by whom these meanings are enacted and interpreted.

The South African context

One such context is, of course, the South African context within which the research for this thesis was conducted. My theoretical standpoint, to be outlined in greater depth in the chapter detailing the methodology for this study, acknowledges the importance of broader cultural meanings as well as individual interpretations and responses to these by individuals enabled and constrained by the features of particular contexts. A review of the literature addressing issues relevant to inhumane practice within the context of the South African health care system is therefore an important precursor to the research presented in subsequent chapters.

While the newspapers describe the state of disarray in which the South African public sector health system finds itself, and the not less than horrific conditions in which patients are treated and the periodic instances in which their rights are grossly violated, as detailed in my introduction to this thesis, there remains very little formal research on the institutional abuse of patients (Lucas & Stevenson, 2005; 2006). News reports sometimes mention particularly traumatic instances, ones in which a patient or relative was particularly outspoken in airing

her complaints, or in which the nature of the event provoked a public outcry. But significantly absent in both formal and informal investigations of medical practice in the South African public sector health system is a concern with the ordinary, routine nature of aberrations of ethical practice, although this is documented by a handful of authors, whose contributions ought to raise significant concern, both on the part of other researchers and of those responsible for South Africa's public sector health services.

Swartz (1989) was the first to explore these issues in South African health care, investigating oppression in the day-to-day functioning of a psychiatric hospital, with particular reference to issues of race and culture, matters of serious concern in light of South Africa's oppressive Apartheid regime, in its heyday during the 1980s. Since then, the majority of research into patients' abuse has been conducted by staff of the treatment facilities themselves, presumably impacting on the relevant researcher's ability to probe those aspects of routine practice that have been normalised within the organisational culture. In addition, the majority of this research relies either on official reports of abuse, which almost certainly underestimate its occurrence (Lucas & Stevenson, 2005), or on interviews with patients, producing only a partial picture of events and eliciting information only about those most deeply imprinted on patients' memories (Fassin, 2008). In addition, such reliance on patients' accounts presumes an ability on the patients' part to engage critically with the manner of their treatment, and to articulate any discomfort experienced, an assumption that seems dangerous in view of the emphasis placed in much of the literature described in the previous chapters on the joint production of patients' passivity and mutual acceptance of the identities, and associated rights and obligations, ascribed to doctors and patients within medical settings. There are, however, some authors who have conducted ethnographic studies, including first hand observation of inhumane and abusive practices taking place in South African public sector hospitals, including Gibson (2004); Jewkes et al. (1998); Baldwin-Ragaven, de Gruchy, and London. (1999); and Fassin (2008), whose work I review in this section.

Medical culture, identity and power in the South African literature

Those authors who have addressed the violation of patients' rights and inhumane practice by health care providers within the South African public sector health system include Swartz (1989); Jewkes et al. (1998); Baldwin-Ragaven et al. (1999); Muller (1999); Williams (2000);

Gibson (2004); Levin (2005a; 2005b); Lucas and Stevenson (2005; 2006); Lund and Flisher (2006); and Fassin (2008).

A number of these authors refer to the more universal aspects of medical culture discussed in the previous two chapters. For example, Swartz refers to the processes whereby psychiatric patients' stories are turned into case histories and their identities reduced to diagnostic categories; Muller (1999) discusses the production of biomedical identities through demarcation of spaces that create relationships of exclusion or belonging, structuring identities in terms of the distinct categories of 'us' and 'others'; and Gibson (2004), from a Foucauldian point of view, explores the medical gaze as a means of producing knowledge and controlling bodies, in the process transforming patients into objects of "observation, measurement and surveillance" (p. 2016). While issues pertinent to more general discussions of medical culture do thus appear in the South African literature, the focus of the majority of these authors lies on the unique South African context, and in particular on the impact of the segregation and Apartheid legislation that dominated the country's history prior to 1994 and that continue to cast their shadow on most aspects of the country's functioning.

The role of the medical profession in Apartheid

In 1977 Steve Biko's death in a South African prison cell focused the attention of the international medical community on the part played by South African health professionals in the gross violations of human rights occurring under the Apartheid regime (Baldwin-Ragaven et al., 1999). Baldwin-Ragaven et al. and Williams (2000) have noted that the role played by the South African medical profession in this country's history of oppression cannot be singularly characterised as one that supported the violation of the rights of black people, pointing out that some of its members have also played an active role throughout South Africa's history in protecting human rights. However, while little objective evidence exists to confirm the occurrence of human rights violations by members of the medical profession during the Apartheid years (Lucas & Stevenson, 2006), the role played by the South African medical profession during and prior to this time is generally acknowledged as 'shameful' (Williams, 2000).

This shameful role included both passive complicity and more active involvement in producing the inequities that continue to characterise South African health care along racial

lines, as well as in gross violations of black patients' rights. Despite many reports of abuse, the South African Medical and Dental Council, one of the two bodies regulating the profession's activities at the time, failed to investigate doctors alleged to be involved in human rights violations (Williams, 2000). Its partner organisation, the South African Medical Association (SAMA), acknowledged its own role in a submission to the Truth and Reconciliation Commission, as follows:

"[Prior to 1981] MASA was relatively silent on human rights initiatives and was part of the apartheid system.... The period [1982-1988] started with justification and defence of apartheid medicine." (MASA, as cited in Williams, 2000, p. 1167-1168).

In its own report, the Truth and Reconciliation Commission condemned MASA for its failure to draw attention to:

"(a) the effects of the socioeconomic consequences of apartheid on the health of black South Africans, (b) the fact that segregated health care facilities were detrimental to the provision of health, (c) the negative impact on the health of millions of South Africans of unequal budgetary allocations for the health care of different 'racial' groups, (d) the fact that solitary confinement is a form of torture and (e) the severe impact of detention on the health of children" (TRC, as cited in Williams, 2000: p. 1168).

Further, the TRC found that the medical profession, "through apathy, acceptance of the status quo and acts of omission, allowed the creation of an environment in which the health of millions of South Africans was neglected, even at times actively compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations of human rights" (TRC, as cited in Baldwin-Ragaven et al., 1999: p. 6).

While the Apartheid era ended officially in 1994 and its duration, as described above, was characterised by an extreme instance of medical professional involvement in human rights abuses, which certainly no longer is the case in this country, it has contributed, as must the historical context of any set of circumstances, to the landscape that currently characterises the public health sector in South Africa.

The South African public sector health system

The profundity of the sense in which the South African health care system has been marked by racial segregation and apartheid is noted by the majority, if not all, of the authors working in this field. Jewkes et al., in 1998, noted the scars left on the system by decades of separatism, oppression and inequality. Baldwin-Ragaven et al. (1999) note the limited services available in certain parts of the country, particularly its rural areas. And almost ten years later, Lund and Flisher (2006) and Fassin (2008) describe the “fragmented, under-resourced and inequitable public health sector” that South Africa has inherited from its oppressive past (Lund and Flisher, 2006, p. 587), arguing that it remains scarred by the Apartheid system, evidenced by the understaffed and poorly equipped health facilities of the former townships. The process of transformation of the health services, Baldwin-Ragaven et al. (1999) observe, has been hindered both by the severe budget constraints that the health sector faces and by the fact that South Africa still does not have a “deeply rooted and universally shared culture of human rights” (p. 47). In these less fortunate parts of the country, in which health services are already understaffed and underequipped, suffering as a result from patient overload and an inability to supply adequate services, staff have to operate under the added pressure of fear of exposure to crime. Muller, for example, cites an instance in which staff were obliged to close a facility for a period of hours as they were “terrified by gangs fighting and shooting outside the hospital” (Cape Argus, as cited in Muller, 1999: p. 7).

Abuse in South African hospitals

While the extreme, state-sanctioned abuse of the Apartheid era is a thing of the past, human rights violations and routinely abusive practices continue to be reported in the South African public health sector. Arguing that ethically unacceptable practices in obstetric services in the South African public sector in fact represent a barrier to access to health care, Jewkes et al. (1998) have documented both clinical neglect and verbal as well as physical abuse of birthing patients by nurses, arguing that while some instances may be described as ‘reactive’ in nature, others are ritualised manifestations of professional and institutional norms. Other authors, including Wood (1997), Stadler (1997) and Mathai (1997) have documented similar types of abuse.

Five years after the official demise of the Apartheid regime, Baldwin-Ragaven et al. (1999) also documented ongoing violations of patients’ rights, arguing that while the South African

Medical and Dental Council and the South African Medical Association had changed in structure, they continued to refrain from proactive investigation of professional misconduct. Furthermore, these authors argue that while South Africa's new constitution enshrines human rights, these had not at the time of writing been effectively incorporated into the curricula offered to medical students.

Acknowledging the complex issues with which health care providers are confronted in delivering health care within the context of the South African public sector health system, these authors raise questions pertaining to the 'coincidental' nature of the continued suffering of particular groups within the South African health care system, identifying those who self harm (most likely to be women), those who are infected with HIV (the majority of whom are black) and those who abuse alcohol (the majority of whom are poor) as those patient groups most likely to receive inferior care. These concerns are echoed six years later by Levin (2005a), who observes the continuing relationship between language, ethnicity, race and socio-economic factors and access to adequate health care within the South African public health sector.

In an interesting analysis of the functioning of the South African medical profession as inseparable from that of its social and political context, Baldwin-Ragaven et al. (1999) cite instances of the difficult ethical decisions with which hospital staff in this context are faced. For example, asking questions about the possibility of acceptable use of physical restraint, they discuss the use of shackles to restrain convict patients currently serving prison sentences and considered to be potentially violent. The authors provide an example in which a convicted rapist was brought to hospital in shackles, which were removed by the hospital for an unknown reason. His subsequent escape had consequences, including the necessity for his victim to abandon her studies and flee to another city.

Muller, also in 1999, documented the mutual abuse of staff and patients, detailing accounts of insensitive and disrespectful treatment, angry outbursts, shouting and 'smacking' of patients by staff and of staff by patients. And in 2006 Lucas and Stevenson provide evidence of the continued prevalence of abusive treatment in South Africa's public sector hospitals, finding that of the 127 patients they interviewed, 50% reported that they had been subjected to abuse by hospital staff. 37% of the patients in their sample reported verbal abuse from staff and

28% reported physical abuse. Of those patients reporting physical abuse, the majority were incidents in which a staff member had pushed a patient. One patient, however, reported having been beaten about the ears by a staff member, one sexually abused and three having been strangled by a staff member, one with a towel. Reported verbal abuse predominantly included threats, insults and ridicule. While measures were in place at the hospital for the processing of complaints and disciplinary action, less than half of those patients who formally reported the relevant incident received any response. As Lucas and Stevenson argue, while in some of these instances it may have been the case that patients provoked staff members, who reacted abusively, such actions are inexcusable even in light of provocation, especially when the perpetrator is a professional caregiver.

Fassin's 2008 publication provides further documentation of continuing violent, abusive and otherwise inhumane practices within the South African public health care sector. Making use of ethnographic methods and spending long hours in the hospital in which he conducted his research, in order to observe its routine functioning, Fassin has provided evidence of disconcerting levels of unethical practice amongst both the doctors and nurses in his study. Among the incidents he mentions are the following: patients being sent by doctors to 'step-down' facilities without adequate investigation of their presenting conditions; patients being ignored who had fallen from their beds and were left lying on the floor; patients waiting to be transferred to another facility not being looked at or fed, sometimes for periods of days, until someone discovered that they were already dead; others who had not been provided with information either about their conditions or about medical procedures, which had been eventually performed without their consent; agitated patients being tied to their beds, so that their agitation increased, while they developed consequential oedema of the extremities, leading after several days to deep sores. Fassin documents these and other instances of abuse and neglect, occurring with disturbing frequency almost up until the present day.

Explanations for abuse in the South African context

Those authors who have documented the above abusive practices in the South African public health service have proposed a range of reasons for the occurrence of this abuse. Jewkes et al. (1998) have argued that reasons for the prevalence of abuse in South African hospitals include the ideological construction of patients as inferior, social norms in terms of which violence is viewed as acceptable, perceptions of staff victimisation by patients, nurses' need

to maintain control, as well as certain structural features including working conditions. The combination of the construction of patients as inferior, a view of compliance as not altogether voluntary, and the culturally acceptable nature of coercive and punitive measures, renders violence a means of establishing the social distance nurses require from their patients in order to maintain their own middle-class and professional identities. In addition, these authors document the existence of a dominant perception that nurses are themselves victimised by patients, viewed as particularly unjust in light of their status as especially deserving of respect, and further justifying their own abusive actions.

Furthermore, these authors relate that, in certain obstetric units, professional insecurities resulting from the inherent uncertainties of childbirth, during which unanticipated complications can arise very suddenly, motivate nurses to strive for an ultimately elusive control over their patients and the environment. As nurses fruitlessly attempt to control what is inherently unpredictable, they frequently resort to scolding and beating their patients, if not to gain immediate control then to ensure it next time. Within this context, patients' failure to comply with nurses' requests and demands tended to produce a sense amongst nurses that they were no longer obligated to provide these uncooperative patients with care, who could therefore justifiably be left, for example, to deliver on their own in the corridors or toilets of the hospital (Jewkes et al., 1998).

In addition to a lack of powerful competing ideologies informing patient care, Jewkes et al. (1998) argue that structural conditions also contribute to nurses' abuse of patients. While the majority of work that has documented patients' abuse has foregrounded structural issues in the explanations they provide, Jewkes et al. argue that it is not so much the structural conditions themselves that encourage inhumane and abusive patient care but rather the tendency toward lack of accountability that these conditions appear to engender in managers, who offer staff's working conditions as a reason for their failure to take action against abusive staff members. For example, these authors quote records of an inspection of nursing quality in KwaZulu-Natal, in which the inspector herself stated that "under existing conditions it is idle and utterly unjust to complain of lack of deportment, courtesy and sense of responsibility among...nurses" (Marks, as cited in Jewkes et al., 1998: p. 29). Also critical of the over-simplicity that characterises explanations prioritising structural factors in the abuse of patients by health care providers, Lucas and Stevenson (2006) argue that while low

salaries, poor working conditions, burnout due to long-term exposure to stress and the social instability characteristic of overcrowded institutions unarguably play their part, social norms swing the compass, determining the direction that the reactions of hospital staff to structural conditions will take. In South Africa's social context, these authors argue, violence has assumed the role of "dominant problem-solving strategy" (p. 200), exerting a profound influence on the functioning of all aspects of the country, including its health system. Lucas and Stevenson's argument is supported by Muller's (1999) observation that physical pain and the threat of physical pain represent the primary means through which hospital staff are empowered, using, for example, patients' fear of pain to protect themselves from those considered potentially violent.

Baldwin-Ragaven et al. (1999) have highlighted the autonomy given the health profession in implementation and monitoring of its ethical codes of conduct, arguing that, while the relationship between society and the medical profession is one of trust, in terms of which health professionals are expected to protect the rights of their patients in return for their right to self-regulation, this trust is open to abuse. In light of the difficult ethical dilemmas that health care professionals face, these authors argue that the 'optional' nature of adherence to ethical codes and the 'moral fortitude' on which such adherence relies represent the greatest flaw in the health professions' codes of conduct. This concern is echoed by Gibson in her 2004 publication, in which she argues that the lack of funds available within the South African public health sector, in particular, amplifies the difficulty of the ethical decisions that medical staff are required to make. For example, decisions about who should get access to limited beds and to optimal care, the need to empty beds as quickly as possible in order to make space for incoming patients and so on render the neutral implementation of policy objectives impossible.

Fassin (2008) discusses the justifications that doctors and nurses provide for discrepancies between their claimed norms and actual practices. This author notes that these justifications revolve in the main around lack of resources, patient workload and patients' deviance and include beliefs such as that nurses and doctors know better than their patients, that patients prefer to have their doctors make decisions on their behalf, that patients are too uneducated to be able to decide for themselves or that patients are undeserving of treatment as a result of having come to the hospital for inadequate reasons, having concealed aspects of their

histories from their doctors, feigned physical pain, defaulted on their treatment regimens or due to being drunk or aggressive. Fassin argues, however, that justifications are not explanations and suggests a more complex interpretation. These moral evaluations of patients, he argues, represent, rather than a simple reason for the relevant patients' subsequent mistreatment, a psychological defence on the part of hospital staff. The differentiation of patients as 'good' or 'bad' enables doctors and nurses to tolerate their own lack of compassion and interest in their patients, identified as 'bad' and hence undeserving of optimal care. In addition to this defensive evaluation of patients, the technical orientation of doctors renders curative activities the only important ones and humanistically-driven actions as incidental. When combined with the organisational imperatives, in terms of which nurses' priorities are to get the round done and the drugs distributed and doctors' are to empty beds as speedily as possible, the disjuncture between ethical codes and actual practice is almost complete.

For this reason, Fassin makes the important argument that assessing ethical practice is less about verifying the extent to which practices conform to specified rules and more about observing practice with a view to determining and accounting for the principles at work. Ethics is therefore about "how everyday practice is performed and justified and how it can be interpreted."

Summary

This chapter has discussed the importance placed within much of the literature on the relevance of the particular context, in terms of which specific individuals are enabled and constrained in the production of action, determining which of the features of medical culture will manifest, and how these will be employed, in the activities of a given setting. A number of authors have discussed doctors' emotional responses to the conditions and illnesses with which they are faced, arguing that, on the one hand, they are not allowed the space within medical settings and (medical) cultural understandings to process these and, on the other, that unacknowledged emotions represent the greatest danger to the quality of care that doctors are able to deliver, leading to an important conclusion, namely that self-reflection, generally discouraged in medical settings, is crucial to ensuring humane medical practice.

The chapter goes on to discuss literature concerning the importance of the particular context

of health care in influencing its form and in producing valid interpretations thereof, identifying a growing field, namely that of hospital ethnography, that attempts to account for this view in its analysis of health care settings. A context particularly relevant to the research presented in this thesis is that of the South African public health system, in which the data for this study was collected. This chapter has therefore reviewed the limited research available on this context, in particular that which relates to the occurrence of abusive practice. With a specific focus on the socio-political context that pervades South African history and continues to exert its influence on a “fragmented, under-resourced and inequitable public health sector” (Lund & Flisher, 2006; Fassin, 2008), the small body of literature that addresses the delivery of inhumane care in South African hospitals documents its continuation into the present.

CHAPTER SIX

METHODOLOGY

In this chapter I set out the theoretical framework in terms of which this project was undertaken and a description of the methods employed in producing the arguments I present. Drawing on Bakhtin's theory of language and consciousness and on Billig's reintroduction of the unconscious into discursive psychology, I begin by discussing some of the key theoretical ideas that informed my thinking. I then set out the ways in which the ethnographic approach and the concept of narrative help to translate these theoretical ideas into research practice and go on to tell the story of the study in such a way as to make my methods accessible for critical review.

The theoretical framework

I set forth in this thesis from a vantage point in terms of which language is understood to represent the medium through which we interpret and communicate our experiences. While I do not maintain that language encapsulates all of human experience (Frosh, 2002), I do believe that its fundamental role in bringing experience into conscious awareness, and its property of rendering that experience visible for empirical investigation, justifies a focus on it. As Frosh points out, those aspects of human experience that cannot be expressed in words are beyond the reaches of research and we can do no more than guess at their nature. The arguments presented in this thesis are therefore a product of my focus on linguistically mediated experience through attention to the details of talk.

From the variety of approaches, ranging from a strict focus on the structure of language to its characterisation as a key to the unconscious recesses of the individual mind, I have chosen to treat language in a manner that emphasizes the use to which it is put in particular contexts, and the effects thereof on the meaning that experiences assume for the various actors within those contexts. Such an approach enables exploration of meaning as fluid and changeable, allowing insight into the particular meanings produced in a given situation and highlighting the possibility for changing those meanings and hence the contexts and actions of those within them. The exploration of language thus becomes not merely a neutral investigation of a supposedly fixed reality, but the emphasis on its formative and therefore potentially

transformative nature allows for the more politically or morally driven activity of exploring the manner in which language is used to structure power relations between people.

The discursive movement in psychology

The value of knowledge produced by traditional methods in psychology is undeniable. However, these methods tell only a part of the story. Attending only to “the firmest, most stable, least changeable and most monosemic aspects of discourse” (Bakhtin, as cited in Shotter & Billig, 1998: p. 21), traditional methods banish the phenomena that are the focus of this thesis beyond the realm of consideration. The “distinctive ‘sensings’ we get when involved in our discourse-intertwined everyday activities with others – the responsive understandings in terms of which we judge whether it is our turn to speak or not, whether others are questioning us or requesting something of us, or are acting sincerely, or ironically, and so on,” (Bakhtin, as cited in Shotter & Billig, 1998: p. 22) are vitally relevant to the domain of interpersonal relationships but are rendered invisible by traditional methods. As the medium through which our consciousness is experienced (Chomsky, 1979), a focus on language as approached in this thesis provides us with a means of getting a grasp on these often chaotic, sometimes ephemeral, and ever-changing elements of social existence.

Bakhtin’s philosophy of language

Central to the methodological approach that I take in this thesis is an emphasis on the interactional nature of discursive action and on its occurrence in meaning-laden contexts. Bakhtin proposed an approach to the study of language that prioritises the communicative event and the meaning of the utterance *as spoken* (Morrow, 1998), as opposed to its structural form. In his own words, “language lives only in the dialogic interaction of those who make use of it” (Bakhtin, as cited in Shotter & Billig, 1998: p.13). More structuralist approaches to the interpretation of talk make for a conception of language in terms of which meaning is seen as finite, complete and carried in the words themselves. From Voloshinov’s (Bakhtin) interactionist point of view, this exclusive focus neglects the creative and evaluative nature of language, denying its capacity to generate new meaning, as well as the creative agency of the individual speaker and the situated nature of human experience in time and space. Instead, Bakhtin’s approach to language allows for the possibility that any particular statement can have multiple meanings. It is only in terms of the context within which a statement is actually uttered that we can know which of these is realised. Rather than carried in the words

themselves as the fixed meaning given in the dictionary, the meaning of words is actualised in the specific context of their use (Voloshinov, 1994a). All utterances are conceptualised as inherently responsive to others in the discursive context and are tailored to account for the responses they themselves anticipate (Nofsinger, 1991). Thus Bakhtin's approach acknowledges both the creative agency of the individual speaker as well as the social context in the production of meaning. It is within this interplay between the individual and the social, he argues, that language assumes its generative potential.

In terms of Bakhtin's approach to language, and its implications for an understanding of consciousness, the self is not the reified, self-contained entity of modernity, composed of 'personality-objects', such as traits, attitudes, emotions and so forth. Instead, it is constituted within linguistically reinforced social practices. Since the social context is a dialogical one, thinking is necessarily also predominantly dialogical, and psychical content is constructed between people, rather than inside their heads (Shotter & Billig, 1998). The individual is therefore inseparable from the social, and the meanings of the words uttered by individuals reflect both personal action and social meanings (Burkitt, 1998). Not only do the utterances of individuals respond to other utterances, and attempt themselves to elicit responses, but the words uttered by individuals are never original. Rather, they have been used countless times by other individuals in other contexts. Thus, words enter particular settings "trailing debris of meaning from the past, 'tasting', to use Bakhtin's... term, of the settings and intentions of their use elsewhere and when" (Smith, 1998: p. 65). The particular utterance of an individual makes use of an already existing language. Language thus not only enables speech, and indeed consciousness, but also sets constraints on what it is possible to say (Voloshinov / Bakhtin, 1994a), and, consequently, on who it is possible to be. In this sense, "Any human verbal utterance is an ideological construct in the small," (Voloshinov / Bakhtin, 1994a: p.45) These key aspects of Bakhtin's understanding of language form the theoretical basis of the methodological approach that I adopt in this thesis. Thus, I approach the talk analysed in the subsequent chapters not merely as reflective of the experiences of individual speakers but as representative and productive of shared social meanings, in this case those characteristic of medical culture, as animated by individuals within a particular context, namely the emergency unit in which this research was conducted.

The return of the unconscious

While drawing on Bakhtin's philosophy, I have attempted also to go beyond it, following the direction taken by Billig in his reintroduction of the unconscious into social psychology. Voloshinov (Bakhtin) (as cited in Shotter & Billig, 1998: p.15) believed that "social psychology is in fact not located anywhere within (in the souls of communicating subjects) but entirely and completely *without* – in the word, in the gesture, the act. There is nothing left unexpressed in it, nothing 'inner' about it – it is wholly on the outside, wholly brought about in exchanges." Billig (1999) argues, however, that this is not so – that *all* experience is not outwardly expressed. Through a reformulation of Freud's concept of repression, Billig argues for the existence of a dialogic unconscious, created silently, rather than by "the word, the gesture, the act," by what is routinely *not* expressed. In opening up certain areas of talk, others are at the same moment closed down. Just as conversation creates the said, it simultaneously creates the unsaid – in as much as it expresses, it also represses. Thus, Billig reintroduces the notion of the unconscious, this time as a dialogical phenomenon created in conversation. Of particular importance to the arguments presented here, this linguistically oriented approach to psychical phenomena renders visible those aspects of human experience traditionally conceived of as internal, and therefore inherently unobservable (Shotter & Billig, 1998). Thus, not only do I treat the talk that is the subject of this thesis as representative and indeed generative of the social context. I also foreground the silences and alternatives that it closes off in the process of its production, exploring the simultaneous impact of these on the possibilities for being and for action.

Translating theory into practice

The above discussion sets out the core theoretical ideas with which I approached this research. Two key concepts were central to my translation of these ideas into research practice and to my choice of the particular methods that I used in producing the arguments at which I eventually arrived. The first is ethnography and the second narrative. The remainder of this section will detail the relevance of these approaches to the above theoretical tenets.

Ethnography

Rather than a clearly demarcated, coherent set of ideas and practices, the field of ethnography is "marked by diversity" (Atkinson & Hammersley, 1994, p257) and might be better

described as an *approach* to exploring and understanding a given context (Atkinson & Pugsley, 2005), or even as a ‘*way of being*’ in a context that one is studying (Atkinson & Hammersley, 1994). This emphasis within what is broadly termed the ethnographic approach represents the central reason for which this approach is relevant to my theoretical standpoint, with the primacy that it gives to the use of language *in context*, rather than in terms of its structural features. In the words of Rampton (cited in Creese, 2008, p 229), speaking of the focus on language within much ethnographic research, “Linguistic ethnography generally holds that language and social life are mutually shaping, and that close analysis of situated language use can provide both fundamental and distinctive insights into the mechanisms and dynamics of social and cultural production in everyday activity.” Such an approach therefore lends itself to exploring social reality as conceptualised in Bakhtinian terms.

Exploration of meaning in dialogical contexts

Historically employed in the study of foreign cultures, ethnography was later used to study subcultures within the researcher’s broader cultural background and has, in more recent times, become widely used as an approach to the study of culture much more broadly defined as systems of meaning. This emphasis on meaning represents a further reason for which the ethnographic approach is so useful to my aims, namely to explore the ways in which the use of language influences the meanings that experiences hold for the actors in a particular context, imbuing the individual’s experience with the ‘flavours’ already present in that context. Focusing not merely on the explicit meanings evident in the content of a particular setting but attempting to shed light on the implicit or underlying meanings in terms of which social life in the relevant context is interpreted and produced, the ethnographer does not assume that people are necessarily consciously aware of the meanings in terms of which they live (Atkinson & Pugsley, 2005). Ethnography therefore enables exploration also of the unstated components of a context, in other words of Billig’s conversational unconscious, or ‘unsaid’, audible between the ‘fleeting little words’ in people’s dialogue.

This latterday form of ethnography, with its focus on culture as comprised of “webs of significance” (Geertz, 1973, cited in Eisenhart, 2001, p5), “inseparable,” in Kondo’s words (cited in Eisenhart, p215), “from the ‘deepest’ aspects of one’s ‘self’,” is associated with a shift in attention from reified cultural systems to the identities that emerge against a backdrop of meanings. This shift foregrounds not only the fluid, dynamic nature of meaning, of which

Bakhtin speaks, but also the interplay between the individual and the social, bringing the agency of the individual speaker into view, as he employs an existing language, already imbued with the “taste” of its use in other contexts and at other times. Ethnography thus defined is therefore well-suited to the study of the dialogical production of social meanings, as animated by individuals through their interaction within specific contexts. Such an approach thus enables exploration, in this case, of medical culture, as enacted by individual doctors (and patients) within a particular hospital’s emergency unit.

Meaning and action

In terms of the fundamental assumption of ethnography then, namely that social life is meaningful, human beings are understood to experience their lives and to act in ways that are rooted in their interpretations of the world around them, and of themselves and each other within it (Atkinson & Pugsley, 2005). According to Gobo (2008), ethnography seeks to understand this meaning-laden context in order to explain social action, thus directly addressing my aim in this thesis, namely to provide insight into how the cultural context of medical practice might explain the provision of inhumane care. As Atkinson and Pugsley note, and of particular importance to my aims here, the ethnographer attempts to understand the culture in which she is interested *in its own terms*, a stance to which these authors refer as cultural relativism. In these terms, the actions and identities of those we study are seen to *make sense* in terms of the meanings prevalent within the context in which they occur (Atkinson & Pugsley, 2005). Human beings are thus assumed to be rational, in terms of the particular ‘webs of significance’ into which they have been socialised. It should be noted that this relativist position does not imply that ‘anything goes’, as in moral relativism. Rather, it acknowledges that moral condemnation alone does not further understanding. In the case of this thesis, therefore, while I, the ethnographer in question, have a clear moral stance on the provision of inhumane care and indeed an aim to contribute to its prevention, I require, paradoxically, an insider’s view, in terms of which the actions I would prevent can be understood as rational.

Shedding light on the tacit knowledge of which the social context is composed and through which its inhabitants construct and reconstruct the context in which they operate in the ordinary processes of their daily lives, ethnography is further able to raise questions about the meanings and power relations that a context engenders, and thus to challenge the inevitability

of its consequences for the identities and actions of those within it. This last brings us to what Manias and Street (2000) call critical ethnography, an approach that extends this ethnographic 'way of being' in the context under study to include not only the purpose of understanding that context, but also of "bringing about human emancipation" within it (Hammersely, cited in Manias and Street, 2000, p 96). This study, which aims to identify discursive practices that enable inhumane care, in order to facilitate the construction of pathways to more humane care, might then be positioned as critical ethnography.

Narrative

Similarly broad in concept and diverse in definition, if more singularly related to the discursive components of the social context that are the focus of this thesis, the concept of narrative provides a further useful tool for bridging the gap between my theoretical ideas and the practical methods employed in this research. Narratives can be described as (partial) representations of the world (Ochs & Capps, 1996), which, in terms of a theoretical approach that highlights the relationship between language and consciousness, structure our representations of reality, selfhood and experience, and thus the meanings that ethnography seeks to explore.

While there are diverse and abundant definitions of narrative, I make use of one particular feature to differentiate it from other conceptualisations of discourse. In the words of Rapport and Overing (2007), "A narrative account involves a sequence of two or more units of information ... such that if the order of the sequence were changed, the meaning of the account would alter." I thus use the concept of sequentiality to differentiate a narrative approach from other similar approaches to understanding the discursive environment. Like Rapport and Overing, I further use it in its broadest sense to refer not only to temporal sequences, as do the majority of authors writing in this field (see, for example, the work of Ochs, 2004) but to any form of sequencing, be it spatial, thematic or in terms of emotional significance (Hollway & Jefferson, 2000b). I thus distinguish between narratives and stories, which might be much more narrowly defined, and allow within their definition not only for obviously bounded units of discourse but also, for example, for snippets of conversation, seen as jointly produced narratives (Ochs, 2004), and indeed for any series of words not randomly generated.

This concept of sequence is especially useful in enabling exploration of the possible implications of discursive constructions for the actions and identities of individuals. Mary Gergen (2001) provides an alternative retelling of a traditional fairy tale, in which a princess saves her prince from an evil dragon. Dismayed by the prince's expression of dissatisfaction with her ruined attire after she has slain the beast, the princess proceeds to ride off alone into the sunset. Our almost inevitable surprise within Western culture at the sequence of events in this story illustrates the power of the original version to influence our understanding of our experiences, and thereby our responses to them, rendering some courses of action far more likely than others. Narratives thus tell us how stories are likely to begin and end, who is likely to initiate what events, commit what actions, possess what characteristics and so on, structuring our understandings and expectations and thereby influencing our actions. While the concept of sequence thus distinguishes narrative from other approaches to the interpretation of discursive activity, a narrative approach to the study of talk involves much more than a focus on sequence. Important simply to note at this juncture, the point will be elaborated in the section below in which I describe the process of analysing talk as narrative.

A further important feature of the narrative approach is its ability to render visible the agency of the individual speaker in the production of discourse. While discursive approaches in general tend to prioritise discourse itself, focusing on the appearance of various features within talk, a narrative approach, through its attention to the relationships between the various elements of an utterance, highlights the creativity of the individual narrator in its production. The concept of narrative thus enables exploration of discursive activity in terms that foreground the social context through facilitating exploration of the "debris of meaning" carried by words that have been used in other contexts, and at the same time highlight the agency of the individual in the way that he makes use of them.

Finally, a narrative approach allows exploration not only of what is said but also of what is not said or, in Billig's terms, of what is conversationally repressed. Narratives represent versions of reality (Ochs & Capps, 1996), attributing certain meanings and not others to people, events or whatever the phenomenon being apprehended. As Ochs and Capps put it revealingly, albeit surprisingly, rather than its opposite, "remembering is a *form* of forgetting" (Kundera, as cited in Ochs & Capps, 1996: p. 21, my emphasis). Narratives thus produce some and close off other ways of understanding reality, again making particular

possibilities for being and for action more or less available (Fordred, 2002). I thus employ Billig's concept of the unsaid to allow the exploration of narrative to give insight not only into what is immediately obvious, but into what Hollway and Jefferson term 'defended subjects', or those aspects of selfhood and experience of which we may not be consciously aware or that we may not intentionally convey. The concept of narrative is particularly sensitive to these 'unsaid' meanings of talk, enabling their exploration through investigation of the relationships between various parts of an account, and thus allowing ambivalence and contradiction to be brought to light and subjected to interpretation.

Defined in these terms, a narrative approach to investigating human experience fits well with the dialogically-oriented vantage point outlined above, sharing its subject-centred, yet non-individualist, interaction-based perspective (de Peuter, 1998), and thus facilitating exploration of the meeting point between self and society, or between the contextually structured meanings and individual actions pertinent to this thesis. These theoretical ideas informed the manner of my approach to this project from its inception to its completion. Far from leaving this theory behind, therefore, the remainder of the chapter will detail its application in practical terms.

The story of the study

The project's inception

The story of this research begins with a conversation I had with a doctor who told me that there was an alarmingly high incidence of diabetic keto-acidosis at a certain secondary-level hospital, located in a poor residential area, adjacent to a major industrial centre in South Africa. Keto-acidosis is a condition often resulting from uncontrolled blood sugar levels over a relatively long period of time, and is thus frequently the result of patients' poor monitoring and management of their conditions. The doctor believed the problem was caused at least in part by the fact that these patients very often failed to return to the hospital for follow-up visits after receiving their initial diagnoses, resulting in crises that might otherwise have been avoided. This in turn, she suspected, was the result of poor relationships between doctors and patients in the emergency unit, where these cases are diagnosed and to which they return when the subsequent crises strike. With these concerns in mind, she suggested that I design a project that might offer some insight into the factors contributing to this situation.

Wanting to produce something with obvious relevance, I fixed on the implications of interactional events for patients' assumption of responsibility for the management of their conditions. After having submitted my proposal and gained approval from the university's and then from the hospital's ethics committee, I was invited to present my research intentions to the doctors and to begin. I therefore attended a meeting held in the doctors' tea room at which the hospital's entire team of doctors was present and I briefly introduced what I wanted to do. With the exception of one doctor who seemed genuinely supportive of my work and another who candidly flung his head into his hands and emitted a groan – "Jesus Christ!" – on hearing that my interest was in interaction with patients, all the doctors professed to believe the project important but raised methodological concerns that suggested their hospital was not the best one for the study. For various reasons they all felt I would be much better off elsewhere. Humouring them by pretending to take their concerns (which were all wholly irrelevant to mine) seriously, but carefully winding the conversation back to a point at which I professed my belief that it remained worth conducting the study at their hospital, I embarked on a set of relationships within which I was obliged to tread very carefully for the duration of the study. While I was unaware at the time of the significance of the defensive front with which I was met at that meeting, and of my response to it, this dynamic was to shape my relationships with the doctors for the duration of the study, and indeed the content and form of the arguments here presented.

Having successfully steered the conversation, if not convinced the doctors of the importance of the project, it was agreed that I would begin the very next Monday. I thus began an initial period of exploratory observation and embarked on a process of searching for evidence of the causal relationships between doctor-patient interactions and patients' subsequent management of their illnesses and treatment. But the more closely I looked the more elusive the treasure became. Not only did the lines of causality in which I was interested become increasingly difficult to pin down but my attention was diverted from these tenuous connections by events that I witnessed and experienced over and over again as the inhumane treatment of patients and the violation of their human dignity. Far from elusive, these events hit me like slaps across the face and left me restless and disturbed, confirming the continued occurrence of abusive and otherwise inhumane practices documented by Lucas and Stevenson (2006) and Fassin (2008) in South African public sector hospitals. A moment that stands out in my memory as a turning point for this project was one that occurred during the

first week of my observations at the hospital. I had joined the doctors' round that morning and we stood at the bed of a man, probably in his late thirties, who was obviously dying. It was the first time that I had ever witnessed the last moments of a human life and I was overwhelmed by the image of what struck me as the slow and painful process of death as it devoured this man's body. As I stood there, attempting to process the scene and my own response to it, the doctors chuckled and laughed somewhat bitterly around the bed, making cynical jokes about the events that had led to what was now certain death. As the ward round moved on and I walked away with the doctors, I felt slightly sick at the flippant manner in which (we?) had treated this man and now left him to die alone and I began to reformulate the causal lines that I was originally intent on exposing into questions about how such undignified treatment of the suffering and dying could have come to be standard procedure.

My focus thus shifted from one that aimed at establishing the causal connections between two sets of events to one on the processes whereby particular kinds of events, namely those that struck me as examples of inhumane care, had become commonplace in an environment ostensibly dedicated to caring for the sick. The project thus evolved with my exposure to the realities of the hospital, eventually producing insights that reflected my shift in focus but that nevertheless have relevance, I believe, for the concerns that the doctor expressed in the conversation in which it was born.

Research questions

The question I ended up posing, and to which this thesis represents a response, centres on the means by which various aspects of medical discourse, as described in the literature reviewed, and as animated by particular individuals in the context of Greenland's hospital, enable doctors in the emergency unit to provide inhumane care and, on occasion, to violate their patients' rights. A number of sub-questions break this broad question down in parallel with the overarching themes of culture, power, identity and the importance of individual participation in particular contexts, identified in the preceding review chapters. They further facilitate exploration of these themes and of their relevance to the provision of inhumane care in keeping with the theoretical tenets of the approach taken in this thesis, namely those discussed with reference to the importance of language and dialogue in the production and reproduction of culture, identity and action by individual agents acting in contexts. The subquestions addressed in this thesis are therefore as follows:

- How is power distributed between the various actors in the emergency unit? What aspects of medical discourse contribute to the attribution of power to doctors and patients within the Greenland's emergency unit? How are these features of medical discourse animated within the context of the Greenland's emergency unit? What, if any, is the relationship between these constructions and the provision of inhumane care?
- What features of medical discourse, as animated within the emergency unit, contribute to the attribution of unequal power to doctors and patients at Greenland's hospital? What is the relationship between these attributions of power and the provision of inhumane care?
- How do the various elements of medical discourse, animated within emergency room talk, enable and constrain doctors' and patients' identities and actions? For example, what identities are readily available to doctors and patients? What identities are less easy for doctors and patients to assume within the discursive context? What courses of action are rendered most and least likely or desirable for the various actors present in the unit? What, if any, is the relationship between the relevant constructions of identity and action and the provision of inhumane care?
- How do the various features of medical discourse contribute to the attribution of agency and responsibility within the unit? How, if at all, do these attributions enable the provision of inhumane care?
- What aspects of the emergency unit's discursive context challenge or contradict the dominant discourses and how are these threats discursively managed?

The setting

Greenland's Hospital serves a population of 1.1 million people and holds a total of 224 beds, processing approximately seven and a half thousand in-patients per month (a total of 91 101 in the financial year 2006 / 07), the period during which the data for this project was collected. According to the hospital's statistics, the ratio of beds occupied in that year was 112% and the fatality rate 7,08%, having decreased from 9,31% in 2005 / 06 and 10,19% in 2004 / 05. The hospital's fatality rate was thus 3,15% higher than that of the secondary-level hospital with the next highest fatality rate for that year, a difference that has remained roughly constant over the last eight years. The hospital consists of four wards (two general

medical and two surgical), a high care unit, an emergency unit and an outpatients department. The hospital's patients are exclusively poor and attend this hospital only for want of preferable medical facilities. The hospital is generally feared by the community it serves, where it is commonly known as "the morgue," and thus represents a last resort for those obliged to use it. Its doctors, predictably, are from middle class backgrounds and, in the context of South Africa's political legacy, live existences outside of the hospital that are entirely separate from their patients' lifeworlds.

The emergency unit

As the point of entry into the hospital, all the patients who come to the hospital pass through the emergency unit first. Thus, while the hospital's statistics are incomplete and not kept up to date, based on the figures for 2006 / 07 an estimated average of 250 patients present at the unit each day. The triage system by means of which patients are classified in terms of the urgency with which they require attention means that not all of these patients ultimately see a doctor. Some are sent home or to a primary healthcare centre on the basis of relatively reassuring results of the initial screening, conducted by nurses in the triage area. While records of the exact number of patients who are in fact attended by an emergency room doctor are not kept up to date, staff estimate an approximate number of eighty patients in the unit at any given moment.

The emergency unit is contained in a large room, in the centre of which is the doctors' station, a set of dilapidated tables pushed together to form a long table and chairs where the doctors write their notes and where certain routine medical equipment is kept (gloves, bottles for blood samples, gauze bandages and so on). Two large open bins stand one on either side of the table displaying warnings in large red letters that they contain dangerous substances and revealing the blood-stained cast-offs of various procedures, used needles and other components of medical waste. The beds are arranged around the edges of the room, and the nurses' station, a counter and cupboards with basic nursing supplies, stands in one corner. The medical holding area juts out from one end of the room. It contains five beds and is lined along its walls with benches, usually overflowing with patients for whom there is no bed available, who sit or slump while they wait to be attended to, sometimes for as long as seventy-two hours. A security guard stands at the gate that leads into the rest of the hospital, preventing traffic in and out of the unit and ready to intervene in the not infrequent scuffles

that break out between patients or between patients and staff. These incidents are almost invariably initiated by an outburst from one of the psychotic patients, whose rantings and ravings form a major part of the proceedings in this area of the unit, where they wait for attention.

A room known as the 'padded cell' leads off the medical holding area and was originally the nurses' tea room but was converted into a locked area for violent or otherwise unmanageable patients. The door opens only from the outside and an alarm that can be activated from the inside should a doctor or patient need urgent assistance wails constantly and is ignored. The relatives' 'comfort room' leads off the medical holding area just next door to the 'padded cell'. It contains a number of chairs and serves as a space in which relatives are informed of a patient's death or can sit to recover from such news. The surgical holding area contains a further four beds and three rows of benches for patients awaiting emergency surgery. This area is more often than not pervaded by an odour of rotting flesh as patients await the amputation of gangrenous toes and feet. Leading off the surgical holding area is the resuscitation area, a confined area with four beds reserved for patients requiring resuscitation but used also, when necessary and possible, for other patients who require a bed. The ECG room is a very small room opposite the resuscitation area containing a bed and an ECG machine.

In general, the unit has an unkempt, dirty and chaotic feel about it. The floor is often spattered with blood and other spillages and a pungent smell, including the odours of urine, faeces, gangrene and disinfectant, permeates the air. The busier the unit, the more marked these features become. Some days the unit hums quietly along but often it is characterised by continuous movement and noise, as patients scream in pain or sing insanely, trolleys are wheeled in and out and doctors rush about the room in a frenzy of constant activity. While there are three doctors' rounds at regular times each day – at 6am; 8am and 4pm – there is otherwise very little evidence of routine. The unit is geared to addressing whatever comes in through its doors and its staff simply respond as and when the need arises and in whatever manner circumstances permit. In theory, each patient, after passing through the triage system, is either sent elsewhere or 'clerked' by a doctor in the emergency unit, during which process the doctor identifies the presenting complaint, takes the patient's history and examines him before making a diagnosis and prescribing a treatment. The patient then waits, either on a

bench or a bed, if available, to receive treatment and then be discharged, transferred or admitted into one of the hospital's wards. In practice, however, this intended sequence of events does not always occur. In a great many instances, the emergency is too imminent for the triage and clerking routines to be warranted or justifiable and the patient is rushed directly into the resuscitation area or into emergency theatre to have, for example, a bullet removed from the head or a stab wound to the heart repaired. On other occasions, an immediate threat of violence may require sedation before any further action can be taken, or the pressure of other patients might mean that no action at all is taken for as long as seventy-two hours. Coupled with the practical goings on in the unit, therefore, is a strange sense of what might be described as bored expectancy – the sense that the unexpected or bizarre could occur at any moment, and indeed that it is only a matter of time before it does. All this is combined with a tired or dull resignation to the fact that, as one doctor put it, “this place is like reality cranked up by ten notches.”

The participants

At the unit's helm is the head of department, a senior physician, seconded by two rotating consultants and then by two senior medical officers. These more senior staff members work only from Monday to Friday and between seven and sixteen hundred hours. Assisting them and running the unit independently after hours are eighteen medical officers (six on duty at any one time) and a number of interns. The medical officers are, with few exceptions, recently qualified doctors, serving out their compulsory community service period, and are rotated every six months. The interns are similarly rotated and there is therefore a constant turnover of staff in the unit. A registrar admits patients into the rest of the hospital and the medical staff are supported by the nurses, two of whom are on duty at a time, and by the security guards.

A total of 22 doctors participated in the study over the year I spent collecting the data. Due to the high turnover, not all doctors were present for the duration of the data collection. While the nurses and security staff might be considered participants to the extent that they were present and that my observations of them and conversations with them did comprise part of my background knowledge of the unit, my primary concern with the discourse of medical culture and its implications meant that my focus was on the doctors. Largely because of the

high-stress work environment, the majority of doctors working in the unit were in the early stages of their careers, there to serve out the required community service period or to acquire the experience necessary to find more comfortable positions. Thus even the most senior doctors in the unit were probably not yet forty. Two of the doctors who participated in the study held the position of senior medical officer, three were consultants, two were registrars and the remaining fourteen held the position of medical officer. Thirteen of the doctors who participated in the study were male and nine female. Particularly relevant within the racialised South African context, it is noteworthy that, while the doctors represent diverse racial groupings, other staff and patients were exclusively black and coloured. In addition, while all the doctors were from middle class backgrounds, patients were all poor. The following table summarises the characteristics of those doctors who participated in the study in terms of professional rank, gender, race and class.

Rank	Gender	Race	Class
Snr. medical officer	Male	White	Middle class
Registrar	Female	White	Middle class
Medical officer	Male	Black	Middle class
Medical officer	Male	White	Middle class
Medical officer	Male	White	Middle class
Medical officer	Female	Black	Middle class
Head of Department	Male	Black	Middle class
Consultant	Male	Black	Middle class
Medical officer	Female	Black	Middle class
Medical officer	Female	White	Middle class
Registrar	Male	White	Middle class
Consultant	Female	Black	Middle class
Medical officer	Female	Black	Middle class
Consultant	Male	Black	Middle class
Medical officer	Female	White	Middle class
Medical officer	Male	White	Middle class
Medical officer	Male	White	Middle class
Snr. medical officer	Male	White	Middle class
Medical officer	Female	White	Middle class
Medical officer	Male	Black	Middle class
Medical officer	Female	Black	Middle class
Medical officer	Male	Black	Middle class

Table 1. Doctors in terms of professional rank, gender, race and class.

The number of patients who participated in the study was great. The constant movement of patients into, within and out of the unit, along with the generally chaotic nature of the environment, made it impossible to record the number of patients included in the research. During the course of the year that I spent collecting the data, however, it is safe to say that there must have been many hundreds.

Ethnographic methods

As noted above, ethnography encompasses a range of diverse methods. Amongst the defining features of its practical application, however, is engagement with the everyday world of the context and actors under study, for an extended period of time (Hammersley & Atkinson, 2007; Atkinson & Pugsely, 2005; Pope, 2005) so as to acquire an understanding of the tacit knowledge and implicit meanings of which it is composed and in terms of which it is produced and reproduced.

Participant observation

The primary medium for achieving this aim is participant observation. Again not a clearly defined or bounded set of practices, participant observation can involve varying degrees of participation in the context of interest, making use of whatever data sources that context makes available. In addition, the role assumed by the researcher engaged in participant observation is not static but adapts in relation to the demands, constraints and possibilities created by the research setting and the actors within it (Pope, 2005). Participant observation is thus a dynamic, evolving practice, the defining feature of which, according to Atkinson and Pugsley (2005, p231) is “the investigation of everyday social life *in situ*,” and by means of which the ethnographer attempts, through observing, listening and participating in the given context, to gradually bring its implicit symbols and meanings to light (Gobo, 2008).

After having introduced the study to the doctors in the tea room, therefore, I began an extensive period, spanning almost a year between April 2006 and March 2007, but with numerous interruptions, during which I ‘hung out’ at the emergency unit. In response to the constraints imposed on my time by other responsibilities and to my periodic need to withdraw from the unit in order to reflect and refine my strategies, this period might be described as consisting of ‘phases’, during some of which I spent two months at a stretch attending the

unit every day and during others of which I ‘popped in’ at the unit for two mornings a week or even spent a few weeks fleshing out my field notes and engaging in the early stages of analysis. All in all, I spent approximately six months’ worth of solid time making my observations. As noted, the study design and therefore the collection of data was dynamic but, as Atkinson and Hammersley (2007) point out, this equates in no way with haphazard. While unstructured and without a predefined set of steps, the design of an ethnographic study is nevertheless crucial to the nature of the knowledge produced. Thus, definition of the task remains open-ended and the design emergent rather than set but the process is no less deliberate and involves continual reflection and decision-making at every step of the way.

I began this process by making use, initially, of as wide a range as possible of the tools of ethnography in an attempt to gain an understanding of how the discursive environment operated to render permissible actions that almost anywhere else would have been deemed unacceptable. At first, the research process literally consisted of just ‘hanging out’ – watching the goings on, listening to the doctors’ talk as they went about their activities, chatting to the patients, reading notices stuck up in the room and generally trying to notice whatever seemed relevant to the place and its inhabitants. On the one hand, I wanted to familiarise myself with the workings of the unit sufficiently, so that I could make some decisions about which aspects of it I wanted to record. And on the other, I sensed instinctively that to be too hasty in whipping out pen and paper might make people uneasy and would be unwise. Instead, I tried unsuccessfully to make myself useful by offering my help with tasks that required no medical skill, but was never taken up on any of these offers, except by the patients, who were only too happy to accept my services in whatever form they were available!

During the months that followed I visited the emergency unit as often as my other responsibilities would allow, arriving in the early morning in time to gain the patients’ consent to record the eight o’clock round, spending the morning chatting with the doctors, observing and recording the events in the unit and leaving in time to allow for a few hours of writing about what I had witnessed and indeed been part of.

The focus of my observations began very broad and I attempted initially to screen out as little as possible, in keeping with my aim to gain a thorough understanding of the context in which the actions I was interested in occurred. I cannot argue, however, that I made no selection in

the events I chose to record. Since I speak and understand only English and Afrikaans, I could not follow the words of those conversations held in Xhosa and I paid only detailed attention to linguistic constructions in the context of English talk, my home language and the tongue in which I am most able to make the kinds of interpretations I offer in this thesis. Later, as my background knowledge became more developed and my concerns more clearly defined, my focus narrowed to hone in on those events that might be characterised as inhumane, and on those other, more routine events, that offered the potential to explain these, either due to their proximity to the event in question, their relevance to that event, as in the case of a conversation about its occurrence, or their broader thematic relevance, as in the case of doctors' private expressions of antagonism toward their patients. The data that I collected thus consist, in keeping with the emphasis in ethnographic work in general, of the everyday and indeed of the unremarkable occurrences in the unit. However, these have not been randomly included and the events that I recorded comprise, rather than a representative sample of all that goes on in the unit, a selection of negative events and those likely to be useful in explaining them.

The research relationships

Inhorn (2004), amongst others, has written about the difficulties ethnographers face, often as unwelcome intruders, in gaining access to medical settings, either due to attempts at exclusion on the part of ethics committees or due to restrictions on the extent to which the ethnographer is permitted, formally or informally, to penetrate the medical setting.

Inhorn (2004) explores how ethnographic access is shaped and limited by participants' powerful feelings concerning privacy and protectiveness. While research very often involves relationships in which the balance of power is tipped in the researcher's favour, this is seldom the case in medical settings, in which the ethnographer is likely to occupy a junior position, at least in terms of professional status (Pope, 2005).

I felt the effects of these power relationships throughout the data collection for this research but most acutely in its early stages. While I was happy to help in any way that I could, those tasks directed by the patients and described above brought me no closer to the doctors, whose conversational arena I was battling to enter. Having picked the emergency unit as that part of the hospital to which it was easiest to gain and maintain access, I found it no small task establishing working relationships there, despite the fact that the doctors and I were of similar

age and socio-economic background. Rather than acceptance of my presence, the doctors' extreme indifference to it, expressed not only in their failure to question or object to my being there, but in the total absence of any of the standard forms of polite acknowledgement, felt more like an extension of what I had already noted as their remarkable ability to ignore disturbing stimuli, from screams of pain or madness to death itself – and, obviously, to unwelcome intruders! Attempting all the usual means of approach – introducing myself individually to each doctor, expressing interest in their activities or striking up conversations about some object or event of mutual concern – I found it impossible to maintain a relationship with any of them beyond the bounds of each isolated conversation, or to establish any kind of rapport. What I needed, in order to gain the kind of access I wanted to the unit's discursive context, was, firstly, acceptance into the doctors' ordinary conversations and, secondly, the kind of relationships with them within which it would be acceptable for me to join them behind the curtains they so frequently drew around the beds before communicating with their patients, excluding me from these important events.

As the weeks went by, and I sat listening to the doctors' talk, I became, in spite of my exclusion, very well versed in the language spoken in the unit, and indeed learnt, I believe, to speak it myself. I learnt the doctors' unflinching responses to pain and suffering, and to its callous treatment - or at least to hide any contrary reaction - and I learnt to understand their humour. Bizarrely, and disturbingly, I began to see the hilarity in the hopelessly unmanageable circumstances and events of the unit, as well as the boredom of continual, repetitive horror. While the process I underwent is a tempting avenue for extensive discussion, suffice it here to say that I began to walk a dangerously fine line between reflecting and assuming the doctors' attitudes. Intending to reassure them by providing a mirror image of what they wished to project, I began the dubious process of contributing to the discourse I hoped to observe – laughing at their jokes, affirming their perspectives at every opportunity and indeed genuinely identifying with them on numerous occasions. I thus allowed myself to become immersed in the unit's culture, slowly shifting from a position from which the doctors' actions frequently seemed incomprehensible and repugnant to one from which they began to be understandable. This precarious new position, often infused with a subtle deception and just as often poised on the brink of denying my personal values, became my *modus operandi* at the hospital. While I never escaped its inherent discomfort, I remained assured of its necessity, initially by the doctors' exaggerated indifference and later

by their smiles of relief when I finished a sentence for them in the way I guessed they would most like to hear it, or when I agreed without question to their attempts to convince me that the reason for their failure to produce an adequate history lay wholly with the patient, that a conflict resulted only from a patient's obnoxious character or that his ignorance of how to take his medication was the product of his failure to listen. The louder I laughed at their jokes, the more communicative their glances became and I established, eventually, a place for myself from which I could watch, almost unhindered, the activities in the unit.

Slowly but surely I was included in the snippets of conversation around the table – the outbursts of frustration when their jobs were made, by some or other circumstance, impossibly difficult, the cynical jokes that seemed to keep them afloat and the discussions about matters outside of the hospital when the unit was quiet. Believing me a ready buyer for their stories, I became someone in conversation with whom the doctors could reassure themselves, opening up the space for the emergence of narratives that my supervisor later read with some surprise as 'confessions'. I think my initial exclusion signalled the underlying insecurities in the unit that my presence as an observer brought to the fore, insecurities that, I will argue later, are almost inevitable in the light of the power imputed to the doctors and the reality of a situation that is, more often than not, beyond their capacity to change. Being watched thus elicited their fears of what inadequacies might be seen, exaggerating their need for reassurance. Thus, they explained to me, the eyes and ears, perhaps, of their own pricking consciences, why they behaved in the ways that they did, why they could not and should not have done otherwise, and why failure was never their fault. And I, in return, reflected what I sensed they wanted to see and hear, opening a space for the production of what might be termed, rather than confessions, 'justificational narratives'. A point of interest with respect to the nature of the relationships I established with the participants in this research concerns the vast discrepancy between the reception the project received from the doctors and that which I received from the patients. In contrast to the defensive, if eventually obliging, response I evoked in the doctors, the patients, with the exception of a few who did not want to be bothered and a few more who remained suspicious of my intentions, believing me a spy for the doctors or an undercover surgeon hungry for a limb, were enthusiastically supportive of my work, wishing to contribute in any way that they could.

Field notes

As Pope (2005, p1182) notes, “Ethnography is rooted in writing.” Only a very short time of observation may take many hours of writing if the details of events, relationships and so on are to be captured and carefully recorded. Those notes taken in the field tend to be merely jottings and represent a starting point only for what are likely to become copious field notes. In the words of Atkinson and Pugsley (2005, p231), “Observations are not undertaken merely for the observer to glean general impressions on the collective personal experiences of settings and events.” Rather, “Detailed observations are...transformed into detailed field notes.”

With the development of the research relationships, it became easier to record the events taking place. I began to keep a journal of events in the unit, from the tiniest snippets of conversations I overheard or in which I engaged, to descriptions of the expressions assumed by the doctors in response to an event or other set of circumstances, and to records of more major events, such as the arrival of a “gunshot”. I scrawled initial notes sometimes openly, sometimes surreptitiously, as if my attention were focused on the other side of the room or on some distant memory, in the process of making my observations, either as the event was happening, or immediately thereafter, working from my memory before any significant time elapsed and obscured the details. In either case, I fleshed these notes out when I returned home each day, adding details as well as descriptions of my impressions and interpretations of what had occurred and eventually producing almost eighty thousand words of field notes.

Audio-recording interaction

Once comfortable working relationships were established, I began asking doctors if I might join them when they attended their patients for the day, a request that was never met with delight but that, in view of our now amicable relationships, was difficult to deny. I thus began observing and audio-recording, in that great majority of instances in which patients agreed, the conversations between doctors and their patients, both during individual consultations and on the rounds, or between doctors, either formal, as on rounds, or informal conversations held around the doctors’ station. In total, I audio recorded approximately forty-two hours of verbal interaction in the emergency unit. I accompanied these recordings with further field-notes, describing what I saw and felt during recorded events and linking these descriptions to the relevant audio-tracks so that they could be analysed together.

A reflexive experiential perspective

The experiential perspective, in terms of which I not only observed and recorded the unit's events but began to assimilate its norms and to identify with its inhabitants, while nevertheless a most valuable vantage point, led to the danger of reproducing, rather than critically analysing, the experiences to which I was exposed (Parker, 2005). I therefore alternated between observing and writing about that which I had seen, making use of my field-notes journal to aid movement between absorption into the unit's culture and a more distanced position. Each day, after returning from the hospital, I spent time writing and reflecting on what had occurred and on my own perceptions and responses to it. Thus, I attempted to maintain my ability to treat the representations of the unit produced within its walls with the suspicion that Parker advises, and thus to avoid the illusion of order and coherence they invariably promised to create.

The interviews

In addition to the wealth of data I had already collected, interviews with the doctors presented an opportunity to elicit their reflections on the events I had observed in the unit, as well as more extended stories depicting these events, useful in terms of my narrative approach and in terms of gaining insight into how they explained and justified their actions and those of their colleagues. Only toward the end of the process, and after I had a much clearer idea of the questions I wanted to answer, did I begin interviewing the doctors, by which time I knew the unit and its workings well. In spite of the friendly relations I had managed to establish, pinning the doctors down to an interview proved difficult and time consuming. Most agreed readily in principle, but in practice the interviews just never happened. The doctors would promise to let me know as soon as they had a spare moment, but that moment, in most cases, never arrived and I spent many days waiting for interviews that never took place. My attempts to secure an interview with doctor S illustrate the push and pull that the process entailed:

“Any chance I might persuade you to an interview?” I asked one day as we stood together at the doctors' station.

“Possibly,” she replied.

“Well, would you mind if I interviewed you then?” I pretended to joke.

“I'm keeping my options open,” she returned.

“Shall I keep working at it?” I laughingly feigned.

“Ja. Get me after a weekend off,” she replied. “I might be more reasonable.”

After an awkward pause during which I subtly, I hoped, refused to drop the matter, she finally agreed – “No, that’s fine,” only to revert to her original position by following up her commitment with, “Sometime.”

Eventually I discovered that I could persuade the doctors to honour their promises by suggesting that we conduct the interview after hours, at which point they almost invariably found a spare moment during the working day, and I successfully completed interviews with twelve of them. I conducted the interviews in the hospital’s various tea rooms, where the relevant doctor and I could sit, largely undisturbed, and chat. The interviews lasted between half an hour and two hours each and were conducted as ordinary conversations, but with an explicit purpose and focus.

Employing a narrative approach to the interview method, as described by Hollway and Jefferson (2000a) I gave the doctors primary responsibility for determining the interview content, thus allowing them to structure the account that they offered and thereby to exert as much influence as possible over the discursive form that it took and the meanings that it generated. I introduced the interviews simply by telling the doctors that I was interested in their reflections on life in the unit, so that I could make use of these in interpreting what I had already observed. I encouraged them to begin by telling me about their experiences of working there, as they saw them, beginning their accounts at any point that seemed important or suitable to them. After this initial request I asked as few questions as possible. Those questions that I did ask were open-ended and requested clarification or further information on a subject that the doctor had already introduced. In recalling issues to which the doctor had alluded earlier in the interview, I attempted, as far as possible, to use the same words that she had chosen, so as to stay within her meaning frame. Following the advice of Anderson and Jack (1991), I probed not only for concrete details but also for the meanings doctors gave to the words that they chose. Anderson and Jack show very clearly the importance of not assuming that a word has the same meaning for one as it does for one’s interviewee. Asking about participants’ personal meanings for words used to describe emotional responses, in particular, can prove very useful in gaining insight into their meaning frame. For example, if a doctor used a word such as ‘stupid’ to describe a patient, event or set of circumstances, I

might ask, “Stupid in what way?”; “What kind of stupid?”; or, “What exactly do you mean by ‘stupid’ in this context?” I further explained to the doctors that I was interested in the details of actual events, inviting them to recall specific instances in as much detail as possible, and attempting to steer them away from the general terms in which they preferred to speak, and toward story-telling, rather than abstract reflection. Thus, I pushed throughout the interviews for stories, following abstract reflections with questions such as, “Can you tell me about a time when that happened?”

In addition to these techniques that might be described as those aimed at ‘following’ the participant’s narrative very closely, I also, if somewhat more tentatively, asked questions that challenged some of their statements (Parker, 2005) or what I suspected might be their omissions. Attempting to employ, to a limited extent, an approach to which Parker (2005: p. 56) refers as one that both “challenges and charms,” I allowed myself slightly more freedom in my responses than merely to humour the doctors. For example, while I encouraged their stories for the most part with affirmative responses – “Of course,” “yes,” “absolutely,” – I also asked, on occasions, questions that implied my potential disagreement – “Do you think so?” – or even overtly stated an alternative point of view. During my interview with Dr P, for example, he complained that his patients refuse to take responsibility for their illnesses, to which I replied that it could also be said that the medical profession tends not to equip them with the information they would require in order to do so. Thus I attempted in my interviews with the doctors to move beyond an approach that simply involves “being nice” to the participants, and to make use also of disagreement or challenge to elicit data (Parker, 2005).

The interview relationships were, however, such that we were both acutely aware that the doctors were doing me a favour by agreeing to spend their valuable time talking to me, and that they reserved the right to cut the conversation short at any moment – after all, it could never be argued that they did not have better things to do. Each interview’s continuation was thus dependent on its ostensible relevance and acceptability from the doctor’s point of view. I felt that the doctors obliged my requests for interviews because I had established relationships with them within which it was hard to refuse, but that their agreement remained conditional on the interview’s potential to maintain their positive self-evaluations. At no point, therefore, did I venture to ask such confrontational questions as, for example, “How d’you feel about giving patients double the standard valium dose?”, “What do you think

about the way you treated that patient who refused to sit down this morning?” or, “Why do you think the doctors here are able to crack jokes at the beds of patients who are obviously suffering?” Instead, I felt compelled to maintain my reassuring responses to their stories and explanations for much of each interview with more accommodating remarks and comments. Interested, furthermore, in the form that their responses took, and in what they tried to convey (Parker, 2005), rather than in ascertaining an irrefutable truth, I had little interest in pinning the doctors down to one point of view or attempting to force them to resolve contradictions, and, by and large, I went along with whatever account they gave me.

In addition to my interviews with the doctors, I chatted to patients informally throughout the time I spent at the hospital and conducted over thirty audio-recorded interviews with them. I similarly conducted numerous informal conversations with nurses and with cleaning and security staff working in the unit. However, as my focus narrowed during the course of the research, and became more finely attuned to the doctors’ perspective, I used these interviews only in the sense that they contributed to my general understanding of the emergency room context, and they were never formally analysed.

Analysis

Transcription

The mass of data produced by the above means was not only more than I could manage but patchy in quality. The constant noise in the unit meant that recordings of doctors’ rounds and of conversations between doctors and patients were frequently interrupted by the overriding sounds of a passing trolley, an announcement on the intercom, another simultaneous conversation and so forth. I therefore transcribed selectively, making use of pieces of conversation that were both audible and of interest for the purposes of the project. I chose pieces of conversation according to the themes that emerged from the observational data, isolating interactions that illustrated the various points. While this means that the conversations presented here were not always transcribed in their entirety, and that some elements of their context may have been lost, I have treated them as snippets of talk located within the broad context of activity in the emergency unit.

I made use of Jefferson's transcript notation (Jefferson, 1984), which emphasizes both detail and readability, making it possible to capture the nuances in talk without compromising intelligibility, adapting it where necessary so as best to convey the meaning as I heard it. For the reason of preserving intelligibility, I adopted a less detailed approach than is used in much of the literature analysing doctor-patient conversations, including such attributes as pauses, indicated by rough approximations of length (one dot represents a momentary pause, two a short pause of a few seconds' duration and three a long pause), false starts, audible breaths and emphasis, as opposed, for example, to every rise and fall in pitch, and without becoming so bogged down in the minutiae of speech as to obscure from view the conversational flow. Transcription was therefore a personalised process of conveying conversations and other snippets of talk in such a way as best to communicate their meaning as I understood it.

Analysing talk as narrative

While much of the material analysed assumed the form of conversation, my analytic method cannot be classified as conversation analysis, which involves employment of specific methods for exploring the structure of conversations, in terms of such features as turn-taking or adjacency pairs, seeking evidence for the explicit presence of specific categories in talk, as opposed to the taken-for-granted assumptions with which this thesis is concerned. My purpose was thus better served by approaching the talk in the unit as narrative, albeit for the most part jointly produced. I therefore employed analytic techniques more often associated with narrative analysis. I refer to my analysis as narrative analysis, distinguishing it from other means of analysing discourse due to its focus on the interrelationships between elements of talk, as discussed above with reference to the concept of sequence. It should be noted that the concept of sequence plays an important part both in distinguishing narrative from other methods as well as in the analytic process itself. However, while it serves to foreground the relationships between elements of talk, it does not exclude, and indeed encompasses, the use of a wide range of other tools for exploring these elements. The assortment of tools that I employed in this analysis is common to a range of approaches to interpreting discourse and will be detailed later in this section.

For now, the focus on the sequences in terms of which units of meaning are related to one another allows investigation of such narrative features as the relationships between characters and between characters and the events and actions narrated. It thereby allows insight into the

likely roles that might be played by various characters and the actions that might be committed by them, as well as into constructions of causality, attributions of agency and responsibility and so on. Mary Gergen (1988), describing grand narratives, or overarching sequences of meaning that structure whole paradigms of thought, provides an example. Scientific narratives employ linear causal sequences, in terms of which stimulus A is understood to directly cause effect B. In these terms, single causes become identifiable as responsible for specific events, allowing for the production of stories that might, for example, blame individual people for unwanted occurrences. Such constructions are in contrast to those made possible by different sequential forms. From a systems perspective, for example, causal relationships are construed as more complex, the relationships between the various events and characters being reciprocal in nature and thus rendering individual blame more difficult.

As stated, however, while the concept of sequence distinguishes narrative from other approaches to the analysis of discourse, a narrative approach to the study of talk involves much more than a focus on sequence, and, as understood in this thesis, may include attention to almost any of the characteristics of talk, including, for example, metaphor, positioning, lexical choices, and so on. From this point of view narrative might then be seen as falling beneath the broader umbrella of discourse, and narrative analysis beneath the umbrella of discourse analysis – sharing many of its features but distinctive in its attention to sequence and thus in its foregrounding of the relationships between elements of discourse.

Using shared cultural understandings

In analysing the narratives that I present in this thesis, I did not adhere strictly to any step-by-step method that can be termed ‘narrative analysis’ and connotes a clearly demarcated set of procedures. As Rom Harre points out (1978: p. 52), the study of social life involves skills that “are more like the skills of literary or dramatic criticism and of poetics than the skills of physical scientists.” I therefore used the understandings I had gained through ethnographic exploration of the context within which the talk was produced in approaching the data, employing these in my use of the variety of analytic tools that I will detail below. Thus, my reading of the material was guided both by the broader cultural knowledge that I share with participants and by my observations in the emergency unit and my experiential knowledge of the space and the people, events and activities within it. Much of the work of interpretation therefore made use of my ordinary skills that, as a communicating individual, I share with

both participants and readers, and that might be described by some as intuition, by others as cultural knowledge and yet by others as, for example, free association (Hollway & Jefferson, 2000a).

I extended the knowledge thus gained by continually asking myself, “How do I know this?” and thus forcing articulation of the interpretative aspects of understanding that we ordinarily take for granted. For example, my own cultural knowledge, which I share to a large extent with the participants in the study, and was able to articulate through the use of various tools for analysing talk, gave me insight into the meanings of metaphors employed by the doctors. For instance, I understood their characterisation of the emergency room, with its high concentration of cases of drug-resistant tuberculosis, as a time-bomb to imply both the war-zone-like nature of the unit, as suggested by the projected explosion of the bomb, and to convey a sense of the inevitability of approaching disaster, suggested by the image of the ticking clock with its connotation of the unstoppable passing of time. These images are well-worn in Western culture and their use in other contexts, such as suspense thriller films, accounts for the ‘debris of meaning’ of which Bakhtin speaks and with which the members of any given culture are intimately familiar. In the same sense, my knowledge of the literature on medical culture and my experiential knowledge of the culture in the Greenland hospital emergency unit in particular, informed the interpretations that I produced through the use of various interpretative tools.

Focusing on the effects of talk

Due to my interest in the implications of discursive practices for the quality of healthcare provided, a key focus of my attention throughout the analytic process was on the effects of talk. I was less interested in establishing the relationship between narrative and some objective reality than I was in imagining the possible social realities that might be produced through the form of its telling. Thus, as a basic point of departure, I approached the talk and other communicative acts I had collected in the emergency room as action and explored their potential effects. I embarked on analysis from the departure point proposed by Bakhtin, therefore, namely that language is not merely reflective but is also productive of the social environment and of individuals’ experiences of and responses to it. Speech act theory provides a useful means of concretising this notion. Making use of Austin’s (1976) notion of ‘perlocutionary force’, or the capacity of language to act on its environment, I therefore focused the analysis on the impact of talk on the social context of its occurrence. Shotter

(1993) illustrates this potential impact of talk poignantly in his analysis of a conversation between two people in which the one tells the other that he loves her. Not only does this statement reflect the speaker's feelings but it fundamentally alters the nature of the relationship between the two people, attributing new roles and responsibilities to each in relation to the other.

Not only such dramatic statements, however, exert an influence on the social context and the individuals of which it is composed. As Billig observes (1999), even the 'fleeting little words' such as 'but' and 'anyway' serve to change the subject of conversation, 'only' to minimise the concept it precedes, 'perhaps' to cast doubt on the truth of a statement, and so on. An example will illustrate the point. In one instance, a doctor, speaking to a patient who had not taken his medication correctly, and whose condition may have been averted by proper usage of the medication, asked the man what brand of cigarettes he smoked. When the man told him, the doctor replied sarcastically, "Oh, so you *can* read." This passing comment made by the doctor, while short and trivial in its explicit content, fundamentally alters the relationship between doctor and patient, and offers a problematic identity to the patient. By drawing attention to the man's ability to read, the doctor implies his fault in not having read the instructions on his medication, representing him as to blame for his own illness and, by implication, as negligent and irresponsible. A further example, in which a doctor requests information about a patient's test results, illustrates the influence that even more fleeting instances of talk can have on the social realities that they generate. Wanting to know a patient's iron level, a doctor asked of her colleague, "What's the iron level?" Following Billig's lead, I argue in this thesis that the choice of even such seemingly insignificant words as 'the', as opposed, in this case, to '*her* (iron level)', which would have been more grammatically correct, can achieve effects as great as to negate the patient as a subject, and thus to relegate concerns about her subjective experience to the background. From this viewpoint, therefore, in terms of which language acts to shape the social environment, I approached the data with questions such as, 'What follows logically from the assumptions inherent in the way that reality is narrated in the emergency room?', 'How do the narrative constructions visible within emergency room talk enable and constrain possibilities for the identities of its inhabitants?' and, 'What actions therefore become comprehensible?' in the forefront of my mind.

Tools for analysing narrative

As stated, I employed an eclectic mix of techniques to explore the sequences by which the talk was characterised and the relationships between its various components and between these and the surrounding medical discourse. In addition to the creative, even intuitive, process alluded to with reference to shared cultural knowledge and my experiential knowledge of the emergency unit's unique culture, I employed more concrete tools for articulating the meanings that I gleaned from the data. These techniques included exploration of such elements of the narratives as lexical choices; deixis; pronouns; conjunctions; subject positions; verb forms; metaphor; metonymy; emplotment; and settings. In this section I will briefly describe the insights offered by some of these tools and the manner in which I made use of them.

Lexical choices, or word choices, convey meanings associated with the particular words chosen, ascribing characteristics to objects, people or events. A narrative approach to analysis of the words people choose to convey their experiences involves investigation not only of the individual words chosen but also of the juxtaposition of these choices in relation to one another. For example, while the choice of the word 'feral' to describe a patient's actions might on its own ascribe an irrational, animalistic quality to the relevant actor, its placement in a story alongside the 'systematic' actions of a doctor further produces a sense of stark differentiation and possibly even hierarchical comparison between the two characters. A number of concepts facilitated my exploration of these choices and their implications for the construction of social reality in the emergency room.

The concept of deixis refers to a word's function of pointing at its referent and assisted investigation of the relationships between speakers and objects of talk. Use of words such as 'that', for example, produce distance between speaker and object, and 'this' the reverse (Simpson, 1993). Thus, the doctors' repeated references to patients as "that patient" imply their separation from the patients indicated, while introduction of a patient as "this woman" brings her closer to the speaker and his audience. Exploration of the use of pronouns produced similar insight into the often implicit relationships between people and between people and actions (Fairclough, 2001). For example, 'we' implies collectivity – "We thought she might be diabetic" and thus shared responsibility – as opposed to 'they', which indicates separation between speaker and object – "They didn't check the patient's sugar level" – and

therefore disassociation of the speaker from the action described. Similarly, analysis of conjunctions can provide interesting insights into the relationships between events. Use of the word ‘so’ to link two events might imply a causal relationship between them – “He kicked me *so* I had him restrained.” In contrast, linking the same two events with the word ‘and’ – “He kicked me *and* I had him restrained” – merely implies their coexistence.

Analysis of verb forms, or transitivity, produced many useful insights into the ways in which the participants attributed responsibility and blame for actions and events (Simpson, 1993). For example, a doctor who narrates his role in an event in such a way that affords him the position of active subject – “I prescribed erythromycin” – foregrounds his responsibility for that prescription, whereas one who narrates her role in a medical mishap in passive terms – “The chest drain wasn’t put in quick enough” – relegates her responsibility for the lack of speed with which the procedure was conducted to the background. While this latter construction still allows the question of who put in the chest drain, she might disappear even further into the shadows of her representation of the same event – “The chest drain didn’t go in quick enough” – by deleting all trace of a responsible agent.

Exploration of subject positions enabled me to locate speakers and others within narrative landscapes, defining not only their relationships to one another but the rights and responsibilities associated with their respective positions (van Langenhove & Harre, 1999). For example, the doctors’ positions in relation to the body of medical knowledge gave them ultimate responsibility and decision making power, and therefore power over the other occupants of the unit. Similarly, patients’ positions as unable to access this body of knowledge rendered them powerless and excluded them from much of the talk in the unit, in which they were unable to participate due to lack of knowledge. The opposite nature of doctors’ and patients’ positions in this sense further created a gap between them, making for distant relationships, characterised by limited communication.

Metaphor and metonymy revealed ways in which thought and action might be structured by cultural understandings of one thing in terms of another, obscuring some and highlighting other possible ways of apprehending things (Lakoff & Johnson, 1980; Lakoff, 1987). Rather than conceptualising the consequences of transmission of drug-resistant bacteria using the metaphor of a time-bomb, for example, and thus implying a sense of inevitability and

possibly even hopelessness, the doctor might have conceptualised the bacteria instead as devious vermin, implying a need for activity on the part of the doctors to outwit them. And the concept of emplotment enabled me to investigate the means by which narrators created coherent stories from multiple incidents, actors, and other features of talk (Ricoeur, 1991), relating these to one another and to their aftermaths, for example through causal as opposed to coincidental relationships (Ochs, 2004). In this regard settings, too, are critical in establishing a plot, not only situating an event but creating a rationale for its occurrence by depicting the preceding events, prior conditions, relevant shared knowledge, and so on (Ochs, 2004).

With the above equipment in the back of my mind, rather than meticulously applied to each and every sentence, I read and reread the data in light of the knowledge I had gained through the process of participant observation, asking questions of the material to aid the analytic process. For example, I asked, what grand narratives are invoked in emergency room talk and what are their consequences for the range of possible identities its inhabitants might assume, or the actions they might commit? Which actors are described as active and which rendered passive by these constructions? What interpretations of reality would one have to accept for the identities they assume and the actions they commit to seem reasonable and warranted (Parker, 2005)? Which events are highlighted and which suppressed in emergency room talk, and what are the consequences of this for the various actors? What silences exist in the stories told? In terms of what story lines do actors attempt to justify the power they wield over others, and their exploitation and suppression (Reisigl & Wodak, 2001)? Are there ambiguities and contradictions in the stories told? What other possible stories might have been told in place of the ones that were? And, finally, how are the answers to the above questions related to the events, in addition to the audio-recorded instances of talk, that I observed in the emergency unit?

Making meaning of narrative

While attending to questions such as these, and in order to aid the production of critically reflective analysis, and to guard against the possibility of reproducing what I was told, along with the norms, values and understandings that I had, to some extent, half consciously, half unwittingly, allowed myself to internalise, I began the process of writing about what I had seen, heard and felt in the emergency unit. I make no pretence in the analysis offered to the production of objective knowledge. As Atkinson (1990, p2) points out, reading (and writing)

the products of ethnographic research involve participation in “complex processes of reality construction and reconstruction.” Rather than an objective representation, therefore, what I present here is my interpretation, produced from within my particular perspective, along with a trail of evidence so that the reader might see how I came to it. My position in the research is central to the analysis, having structured the arguments presented from the very beginning, from the construction of the research questions, to the relationships I formed within the emergency unit, allowing some and not other things to happen during the research process (Parker, 2005), and finally to the sense that I made of it all.

Ethical considerations

From the first chaotic moments of my observations at the hospital I felt the need for what Reissman (2005) refers to as “a situated ethics ... (that) provide(s) room for particularities that unfold during the fieldwork” (p. 487). I began by attempting, relatively unthinkingly, to employ the traditional ethical procedures required by every ethics committee, involving obtaining written consent from research participants in return for assurances of anonymity, confidentiality, respect for the right to withdraw at any stage, and so on. I found, however, no sooner had I begun, that traditional ethical practices offer a highly regimented and abstract solution to the management of dilemmas that arise in often chaotic realities, frequently fraught with unpredictable difficulties. As Pope (2005) notes, standard ethics procedures are designed primarily with quantitative experimental research in mind and frequently fail to address the kinds of issues that arise in ethnographic research.

Consent

While establishing the doctors’ consent for their participation in the research might be viewed as a straightforward procedure, and was, at face value, indeed so straightforward, accepting this interpretation of the consent process would be inconsistent with my approach to the rest of the material presented in this thesis. As noted by Pope (2005), neither ethnography nor consent to participate in it are single events but rather involve protracted processes of negotiation. As described above, I introduced the research for the first time to the doctors before it commenced, at a meeting where all professed their esteem for the project but where I heard, too, the first sounds of their ambivalence. Indeed, each doctor that participated in the research went on to agree whole-heartedly with the project’s aims as I explained to them in subsequent individual conversations held with each of them, and to sign the consent forms I

offered. However, the research relationships that persisted throughout the time I spent at the hospital belie the apparent simplicity of these interactions, which must, I believe, be seen, along with the rest of the material produced, as aspects of the doctors' self-presentations and thus must be viewed with suspicion (Parker, 2005). With such benign aims as the analysis of doctor-patient communication and the promise such analysis holds for the future benefit of patients, what doctor who wishes to believe herself a concerned professional, dedicated to quality patient care, and who wishes further to be perceived in this light, could refuse?

In addition to the often thinly concealed ambivalence I perceived in the doctors' willingness to participate, I discerned also what might be described as a 'paradigm difference' between us, in terms of which I knew that they, with their background in natural science, would perceive in my intentions only those aspects relevant to "the firmest, most stable, least changeable and most monosemic aspects of discourse," discussed by Bakhtin, as above. Already convinced of their ambivalence with respect to the project, I was not about to contradict them. I was unready to believe, had I detailed my intentions – "No, no, I believe you misunderstand me! I mean to go through the smallest details of your speech with a fine tooth comb in order to reveal not only what you say but also what you wish to conceal, both from me and from yourself!" – that a single one of them would have agreed to continue. While I maintained throughout the research process an ongoing conversation with the doctors with whom I worked about its shape and focus, I gave them an outline, rather than a detailed understanding of my object and means of inquiry. I told them that I was interested in the difficulties that arise in the communication and relationships between doctors and their patients and I guessed, I believe correctly, that they would assume I referred only to those related, for example, to the successful conveyance of information, the inappropriate use of medical jargon or the problems doctors face when they and their patients do not speak a common tongue. While I told them I was interested in agency and responsibility within these relationships, and even in their production through the details of language, I knew they would think only of how better to ensure that their patients comply. The process of establishing the doctors' consent was thus problematic from the outset, largely due to the nature of my research interests, which led me and the participants into waters in which neither of us was able to be entirely honest.

Interestingly, in spite of prevalent ideas about the vulnerability of patients to exploitation and their consequent need for protection from people like researchers, who might appropriate their misfortunes for personal benefit, the process of gaining the patients' consent was, I believe, far more straightforward. Perhaps because they were there to receive care rather than to give it, and so less susceptible to the performance anxieties doctors may have experienced, and perhaps because many of them were too ill to be much bothered with the trivialities of politeness, I sensed a far greater honesty in my interactions with them. The vast majority of patients responded enthusiastically to hearing about the project, indeed expressing gratitude rather than any sense of powerlessness to refuse their participation. I explained to the patients that I was a researcher from the University of Cape Town and that I was studying the communication between doctors and patients at the hospital with the intention of finding explanations for the problems that frequently occurred. These introductions were met, in most cases, with a torrent of stories proclaiming the patients' identification with the subject and asserting its importance.

Producing consent forms, however, was less well received and, as reported by Inhorn (2004), has been identified by many ethnographic researchers as an impediment to building rapport with participants. My initial approach was to supply patients with an information sheet, in English, Afrikaans and Xhosa, so that each patient could read it in her mother tongue, outlining the project's aims and patients' rights and requesting a signature. However, many even of those patients who responded most enthusiastically to my accompanying verbal explanation expressed suspicion and reluctance as soon as I produced a pen. It struck me, on consideration, that when patients in a hospital are asked for a signature it is frequently to confirm their consent to a risky procedure, more often than not anaesthesia and surgery. I think that this connotation contaminated what were almost always their otherwise very positive responses to the project and I therefore opted instead to audio record their consent, an option to which only very few raised objections. I explained that the purpose of the recording was to satisfy the university that I had in fact received their permission and that I had informed them of their right not to participate at all, to withdraw at any stage, and to confidentiality. In the vast majority of cases, these explanations led to sincere gratitude from the patients, in place of the suspicions that followed requests for signatures on forms.

Having resolved the matter of obtaining a verifiable record of consent, I faced other unanticipated difficulties, such as those surrounding the recording of the doctors' talk at the foot of an unconscious patient's bed. Of course, the unconscious patient was emitting no sound and therefore could not be recorded. But was it a breach of his right to confidentiality to record the doctors' words spoken about him? Since my focus was on the doctors and their actions in these instances, not on the patients, I decided it was not. In addition, I felt that it would be the more unethical practice to leave all unconscious patients behind closed doors. These patients are amongst the most vulnerable, as illustrated by the rough treatment of them I observed on occasions. In one instance, a doctor attempted to show another doctor, for interest's sake, or so it seemed, the extent to which an unconscious man was unresponsive to pain. Twisting the man's nipple violently, he displayed the lack of reaction repeatedly and then sauntered away from the bed. It was instances such as this one that settled the matter for me, convincing me of the importance of reporting the treatment of unconscious patients precisely for the reason that they could neither give their consent nor report the treatment themselves.

I opted not to make audio-recordings of doctors' conversations with psychotic patients, however, who would similarly be unable to give their legal consent, and who were seldom accompanied by a relative from whom I might obtain it instead. The psychotic content of many of these conversations further suggested the need for a different approach to analysis and thus rendered their exclusion relatively unproblematic for the purposes of the research. I did, however, continue my observations as usual in these instances for the same reasons discussed with respect to unconscious patients.

Confidentiality

Again, confidentiality presents more complex issues for the doctors than it does for the patients. As regards the patients, confidentiality could be guaranteed from the outset – even I would have trouble tracing instances of talk to individual patients, each being merely one amongst more than I would be willing to count, and only snippets of their talk being here employed. The doctors, however, are in another category. Relatively lengthy narratives were often required to gain insight into the psychological phenomena in which I was interested, rendering the excerpts presented in this thesis, while modified to disguise any definitively identifying features, potentially recognisable both to the doctors who produced them and in

many cases, I am sure, to their colleagues. As Hollway and Jefferson (2000a) point out, the nature of the subjects of psychological research as *defended* subjects means that some of the interpretations offered may come, should participants discover them, as a painful surprise. While the findings of this thesis can be fed back to the hospital in a manner sufficiently abbreviated that these concerns are alleviated in that context, similar abbreviation of publications based on the project would obscure too much of the insight it offers. There thus remains an unresolved conflict of interest between possible harm to participants in the, albeit unlikely, event that they stumble upon interpretations that challenge their defences or offend in some other way, and the possible benefits to future doctors and patients of the availability of this information.

Concealment of the hospital's identity produces similar issues. While overtly identifying information has not been given, someone intimately familiar with the hospital may well recognise it. My personal belief is, however, that the findings of research such as this should be published as part of the attempt to improve the lot of patients in already overcrowded and under-resourced hospitals, and that the possibility of this benefit outweighs any possible harm.

Sensitive research

While standard ethical procedures were clearly, therefore, not developed with projects such as this one in mind, I believe that a situated approach to conducting research ethically can be successfully implemented by attending to and respecting both researchers' and participants' emotional responses during the course of the research (Reissman, 2005). I was therefore attuned throughout to my intuitive experiences of the research relationships, avoiding intruding on patients whom I sensed would prefer not to be bothered, whether or not they verbalised this, leaving private spaces when I felt my presence might be a disturbance, for example in the case of an examination that might be humiliating, when relatives were informed of a patient's death and the presence of an observer seemed potentially offensive, or when I sensed that my observations made a doctor particularly uncomfortable. As Reissman (2005) and Hollway and Jefferson (2000a) have already pointed out and begun the process of amending, no guidelines exist to structure the judgements required, and the ethical conduct of research of this nature thus remains a process of feeling one's way along with only those

most distrusted components of the research process – one's own emotional responses and intuitive sensings – as guide.

The project's aims

At the outset, a word in clarification of my purpose in undertaking this project is in order. My intention is to offer an explanation of how the discursive context in the emergency unit, framed by the meanings imposed by broader medical culture and animated by the individual inhabitants of the unit within its unique social space, paves the way for the provision of inhumane care and, at times, the violation of patients' rights. The inimical actions of doctors therefore constitute my area of focus but should not be taken to be representative of all that occurs in the unit. Rather, they are illustrative of that which I have identified as contributing to the possibility for oppression and abuse. The reader should note also that doctors' actions are responses not only to their positions in the narratives outlined here, but also to the immense pressure they are under as doctors at the point of entry to the one of the busiest hospitals in the province, within a system that all too frequently leaves them feeling frustrated, angry and impotent. My argument, therefore, is not intended to damn the doctors present in these pages, but rather to offer an explanation of how the discursive surrounds make certain actions and identities more, and others less, available to doctors reacting to the hugely demanding circumstances with which they are faced; and thereby hopefully to open up possibilities for finding alternative ways of responding to an environment that, in its material features, is unlikely to change dramatically for the better in the foreseeable future.

CHAPTER SEVEN

PILLARS OF MEDICAL POWER: GODS, SCIENTISTS, AND MEN IN THE EMERGENCY ROOM

A variety of both discursive and material factors combine in the emergency unit at Greenland's hospital, enabling doctors to assume identities of power. Focusing on the discursive features that are the primary concern of this thesis, I will explore in this chapter the ways in which narrative frameworks identified in the literature on medical culture and available within the Greenland's emergency unit, facilitate the adoption of identities by the doctors and enable justification of actions that would, under other discursive conditions, be unacceptable to both patients and staff but that in this environment go almost unnoticed. I will further attempt in this chapter to shed light on what might be termed the narrative 'underbelly', or those aspects of emergency-room talk that appear discordant with the powerful position that these narratives afford the doctors, offering insight into the relationship between the sometimes paradoxical elements of the doctors' discourse.

Gods in white

Along with the narrative framework that I will explore in this chapter, there are a number of other factors, including socio-cultural and historical features of the broader environment and opportunities and constraints offered by the institutional environment, that are less the focus of this thesis but that nevertheless influence the power available to doctors in the Greenland's emergency unit. The more tangible origins of doctors' power indeed bring a god-like aspect to their construction and doctors are transformed from mere health care workers into '*götter in weiss*', as they are sometimes known in German (Wodak, 1996). A number of authors, including Fox (1989), Good (1994), Obholzer (1994), Kellerher, Gabe and Williams (1994) and van der Geest (2005), have drawn attention, as discussed in chapter two, to the parallels in the historical development and social roles played by medicine and religion. Others (for example, Millman, 1977; Mizrahi, 1986; and Kellerher, Gabe and Williams, 1994) have noted, however, that irrespective of these more interpretive dimensions, doctors are in fact involved in the practice of saving lives and relieving pain, a practice that involves making decisions about who will receive what treatment and therefore, ultimately, about who will live and who will die (Millman, 1977; Mizrahi, 1986). Patients are inevitably, therefore, dependent on

doctors to a very great extent, a material circumstance that itself gives rise to power imbalances and makes easy the doctors' assumption of dominant and indeed god-like positions. The following extracts reveal the very real power that doctors hold over their patients:

“There was a case of a man who's had TB in the past. HIV positive, (.) probably late forties, fifties. Not- not old at all. Thin guy, wasted. Seen last night (.) very distressed and short of breath. They saw his chest x-ray, they were- they weren't quite sure if it was from lung destruction or if he had a pneumothorax with air outside the lung and they decided (.) no – cos it was very busy last night – no, it's just from lung destruction (.) just admit him and he's gonna die. (..) And (.) with the luxury of a bit more time this morning we said no and I put a chest drain in him and he's now fine. (..) Completely changed. Doesn't need oxygen anymore.”

Dr G, standing over the bed of a woman during his ward round, decides:

“If she doesn't have miliary² TB, its untreatable at the age of eighty. I think, basically, she goes to Rosedale³. TB treatment. If she doesn't get better, nothing else. [To the other doctors] Do you agree?”

And a premature baby, delivered at twenty four weeks, would receive some of the available treatments but not others, since she was “not going to do well anyway.”

These extracts illustrate the extent to which doctors in fact 'play god'. In an under-resourced hospital such as Greenlands, treating a patient sometimes means deciding to withhold treatment based on a poor prognosis, and instead employing scarce resources where they are likely to have more effect. In the first example, insufficient time led to an inaccurate diagnosis and the patient would have been left to die, if there had not been more time to consider all the possibilities the following morning, leading to a radically altered outcome. In the second instance, the patient is given the chance to respond to one treatment attempt only, since her age makes justifying the employment of further resources impossible. And in the third instance, only limited treatment will be made available to a baby with a poor prognosis.

² Tuberculosis in parts of the body other than the lungs.

³ An external ward.

The first doctor clearly embraces his position, entering the story as a distinct individual for the first time as hero – “And I put a chest drain in him and he’s now fine.” The very real power that he exercises, as do the second and third doctors in their somewhat antithetic role, makes his paramount position, however, arguably inevitable.

While my emphasis on narrative therefore by no means denies the simultaneous relevance of doctors’ tangible power, for example, to avert death and relieve pain, my aim is to outline, through an analysis of the characters, storylines and events, values, assumptions, humour and lexical choices that they employ, the ways in which the discursive features of medical culture enable and constrain understandings of the doctors’ identities and actions within this particular context. My argument is, in keeping with my theoretical recognition of individual agency, that the ways in which doctors respond to the circumstances with which they are faced and the positions available to them are never really beyond their control but are engendered through their persistent animation of the relevant narratives. One might imagine the doctor’s position in this sense as a point in time and social space on which many different stories converge to produce possibilities for being and for action (Fordred, 2002). In keeping with the arguments of authors such as Fisher (1991), Silverman (1987), Wodak (1996) and Atkinson (2004), namely that medical settings should not be understood in terms of a monologic discourse but that they encompass multiple discourses, some in parallel, others potentially contradictory, I will attempt to show how individual doctors choose to pursue, forgo or even creatively adapt the identities and actions available within medical discourse. In the remainder of this chapter I will detail the narrative landscape that the emergency unit’s doctors inhabit and bring to life, attempting to trace potential pathways between these and the acts of inhumane care in which I am interested.

Narrative pillars of medical power

Two broad narratives, the features of which are prominent within the literature describing medical culture in general, dominate doctors’ self-presentations in the unit, and contribute, along with their material control over life-saving resources, toward their elevation to the position of power that they occupy, a position that, I will argue later in the chapter, is nevertheless fraught with ambivalence. The first of these narrative frameworks is that of science and the second that of masculinity. The characters of scientist and of strong, masculine hero are, as pointed out by a number of authors, available to doctors within the

broader medical culture. So too are the associated causal sequences, attributions of agency and responsibility, beginning and end points of stories, plot lines and so on that are reflected and reproduced in the discourse at Greenland's emergency unit. The combination of the narratives of science and of masculinity is a particularly potent and dangerous one: the appeal to science implies that doctors are both superior and unquestionable; and traditional narratives of masculinity offer the opportunity for aggressive domination. These constructions, I will argue, enable the justification of acts and omissions that, in terms of other story-frameworks, would surely be seen as reprehensible.

The narrative of science

As discussed in the review of the literature on medical culture in chapter two, authors including Mishler (1984), Fisher (1991), Mizrahi (1986), Wodak (1996) and DeVecchio-Good (1995) have noted the pervasive nature of scientific discourse throughout medical talk and practice. These and other authors have drawn attention to key features of scientific discourse. Most importantly in this context are its claims with respect to the objective, rational and certain nature of scientific knowledge, which is consequently construed as superior to all other forms of knowledge. Contingent upon this premise, scientific endeavour, directed by superior knowledge, or designed to produce such knowledge in order to direct future actions, assumes greater importance than all other forms of activity. This preoccupation with scientific knowledge and action has been shown to have facilitated a shift from the practice of humane to technological medicine (Mishler, 1984) and, I will argue, enables and justifies the delivery of inhumane care.

I have chosen to call this aspect of medical discourse the 'narrative of science', rather than merely scientific discourse, in order to highlight the relationship between its components and to convey its coherence as a structure for making sense of the world. I treat its features, in these terms, as related parts of an overarching framework, rather than as independent elements of talk, that together and in relationship with one another, have the potential to influence people's understandings of how stories are likely to begin and end; why events occur; what is likely to happen first and what is likely to happen next; who is more or less likely to play the protagonist; possess what kinds of character traits; be responsible for what events; capable of what action; and so on and so forth. Through the ways in which it

structures understandings and explanations of diverse events, I argue that the narrative of science enables actions that are driven, paradoxically, not by science but by pragmatic or even less rational concerns and that sometimes result, rather than in the provision of good quality medical care, in the violation of patients' rights. The presence of this narrative, rather than overtly identifiable through explicit statements of allegiance, is visible in the patterned appearance of its characteristic features throughout the details of the doctors' talk. In the remainder of this section I will detail key characteristics of the narrative of science and suggest relationships between these and the occurrence of inhumane care.

Knowledge and superiority

As argued by the authors referred to above, medical knowledge is construed as superior in terms of its scientific and hence objective, rational and certain status. Authors including Atkinson (1981; 1984), Mishler (1984), Katz (1984), Wodak (1996), Allsop and Mulcahy (1999) and Helman (2001), argue further that its construction as such protects doctors from the self-doubt they might experience were they to recognise the limitations of medical knowledge, as well as from the doubts of their patients, maintaining the prevailing norm, "Thou shalt trust physicians" (Freidson, 1975: p. 124), and thereby contributing to the establishment and maintenance of doctors' supreme positions.

Echoing the findings of the authors referred to above, the importance of doctors' knowledge in establishing their superior status in the Greenland's emergency unit is evident in a wide range of discursive practices in the unit, including their 'knowledge displays' for each other and their use of knowledge to position themselves and assign places to others in the hierarchy, and to include some and exclude others from the communication ambit. For example, junior doctors who have recently arrived in the unit can often be heard casually employing scientific jargon with a nonchalance that asserts their familiarity with the language and claims for them their membership of the medical fraternity. More senior doctors can be seen pelting students with questions that they are unable to answer, leading to the students' embarrassment and an opportunity for the doctor to display his superior status. While in itself all of this may be relatively harmless, and I have never seen it done with any malice, amongst its effects is the demarcation of boundaries between doctors and others, marking some as superior and others as inferior and thus contributing to the possibility for domination.

This particular form of superiority bestows more weight on the content of the utterances of a doctor than can be attributed to the words of any other. Not only is the doctor elevated in stature, but his power to act is increased by the presumed excellence of his judgement, with the result that his conduct requires very little justification and leaves even less room for questioning from anyone outside of the medical fraternity. Doctors' knowledge in the emergency unit at Greenlands is very often treated as the most, often the only, reliable source of information, while, as noted in previous research by authors including Mizrahi (1986), Atkinson (1995), Antaki, (1994) and Donnelly (1997), patients' accounts are treated as possessing all the suspect qualities of subjectively based information and dismissed as fiction rather than fact (Arney and Bergen, 1984). For example, a doctor might ask his colleague for background information about a conscious and lucid patient who is standing before him – "What's her name?"; "When did she come in?" While such an observation might seem to overemphasize a minor detail of conversation, imagining this scenario in another context reveals its strangeness. The incongruity of looking on while being introduced by a mutual acquaintance to someone else, who enquires of the acquaintance after your name and recent movements, who in turn responds on your behalf, is so conventionally inappropriate, and your surprise and dismay likely to be so great, that one can only guess at the effect on the feelings of the patient of such a practice in the hospital. While this is so, the fact should not be ignored that these 'oversights' in terms of which doctors fail to communicate directly with their patients are certainly not intended to disrespect or offend them. Rather, they represent responses available within the discursive environment and employed in the negotiation of excessive time constraints, in a context in which the assortment of obstacles to effective communication with patients frequently render bypassing this route in favour of an option that seems, in terms of its immediate effects at least, to be more efficient.

But more disturbing than the breeches of normal etiquette in which the patient is either not addressed or in which his contributions to the conversation are ignored, are the opportunities this authority offers doctors to override their patients' rights, for example to accurate information about their conditions, or to use what one might call their 'easy access' to credibility to achieve their own ends. Dr F was finding a patient accompanied by her daughter difficult to manage. The patient and daughter were asking for explicit information: What were they waiting for? When would the doctor be back? How long before the test results would be available? What were the doctor's suspicions as to the cause of illness? Feeling

under pressure to provide answers she did not have, Dr F admitted, out of the patient's hearing, "I'm just hoping that there is something on the X-ray so that I can say that is your problem." If not, however, she assured me she would "probably end up telling the patient she's got pneumonia and discharge her with amoxicillin – not because that is what I really really think but because she wants an answer."

"Really?" I replied in surprise. "You'll actually just make something up?"

"Definitely!", she said. "We make up stories big time – all the time. Because you have to get rid of patients somehow."

This extract represents an interesting example of the complex interplay between the narrative of science and the other features and constraints of the emergency unit setting. On the one hand, the doctor in this example is overtly engaged in a scientific activity, namely attempting to find the cause of the patient's illness and thus to make a diagnosis. Simultaneously, however, she has a second pragmatic rather than scientific objective, namely to discharge the patient, an aim she intends to achieve with or without the diagnosis. Dr F thus employs her position within the narrative of science, namely that of someone who can make scientific pronouncements, not only to accomplish the hoped for diagnosis and to give a prescription, but to allow her, should her attempts in this regard fail, to proceed in "get(ting) rid of (the) patient somehow." Thus, she uses the fallacy of certainty conferred on her pronouncements by the narrative of science to allow her to claim scientific knowledge that she in fact does not have, and get away with it, defending herself against this patient's questions and doubts (Katz, 1984; Allsop & Mulcahy, 1999) and against general patient overload. Exempt from the requirement of justifying her diagnosis before her patients in terms of the pre-existing assumption that her statements are rationally derived and objectively true, the doctor uses the opportunity thereby afforded her to unburden herself of the patient by providing a diagnosis that will facilitate speedy discharge. She thus uses her authoritative position, as Katz (1984) and Millman (1977) suggest is all too often the case, to protect her own, rather than her patient's interests.

The position of ignorance that the patient occupies within this narrative not only keeps the doctor safe from possible questions about the correctness of her diagnosis, thus, as Wicks (1998) argues, shielding her from external evaluation. It also renders her intention to provide her patient with misinformation appropriate and quite inconsequential. In terms of the

narrative possibilities, the patient's ignorance cannot substantially change, as she is incapable of comprehending medical realities (Millman, 1977), and the lie is therefore insignificant and permissible. The doctor thus paradoxically puts her own and her patients' position within the narrative of science to anti-scientific use, revealing both the power of the narrative of science and the simultaneously moral and political (and thence antiscientific) nature of medical practice, as discussed by Fisher (1986), Mishler (1984), Mizrahi (1986), Lewinsohn (1998), Wodak (1996) and Donnelly, (1997) amongst others.

While more disturbing than the omission to greet the patient described above, it should also not be overlooked that this extract does not simply represent an abuse of power for its own sake. Rather, the doctor is responding to the circumstances within which she finds herself, namely ones in which she is faced with massive patient overload and is probably suffering from both stress and exhaustion, by employing the means discursively available to her. Indeed, the urgency of some patients' conditions requires that doctors manage the load by "get(ting) rid" of others. My argument, therefore, is not that Dr F particularly wants to lie to the patient or otherwise violate her rights, but rather that the discursive context makes this option readily available and that, faced with a difficult set of circumstances, she employs it for her own protection and, coincidentally, at her patient's expense. The status associated with access to superior knowledge is thus made available to doctors through their position within the narrative framework, rather than merely through their actual possession of such knowledge. It is further employed to bolster this position, as Phillips (1996) has shown, through the moment-to-moment production and reinforcement of their patients' ignorance.

The supremacy of scientific practice

As Mishler (1981) points out, not only scientific knowledge, but the practice of science is charged with greater importance than any other activity. Doctors' duties and actions are therefore prioritised, both because they are presumed to be guided by superior knowledge and because they represent scientific endeavour, with its valued attributes of rationality, objectivity, linear causality and technical action (Mishler, 1981; 1984; Mizrahi, 1986; Conrad, 1988; Stokes, 1994; Wodak, 1996; Atkinson, 1999; Good and DelVecchio-Good, 2000). This 'truth' underlies a great deal of the activity in the emergency unit and Dr S makes it explicit in the following extract from my conversation with her:

Dr S: Although they claim that we should take breaks there's no ways we take breaks, it doesn't happen...You never see the nurses not taking their breaks, the doctors do not.

I: Really (..) Why d'you think that is?

Dr S: I don't know, I suppose we have more sense of guilt that you can't sit around (.) for an hour on your arse (.) while (.) there's so many sick people out there.

I: So why would doctors have more of a sense of guilt than nurses?

Dr S: Because if anything- I m- I- I mean because we just more- we do more of the things to change the co- the outcome.

I: Ok.

Dr S: That's why.

While this excerpt overtly states the primacy of doctors' activities, interesting too is Dr S's uncertainty in attempting to provide a reason for their greater importance – “if anything- I m- I- I mean because we just more-” – eventually formulating the maxim that, “We do more of the things to change the...outcome.” The cause-effect sequence identifiable in this syntax is identified by Helman (2001), amongst others, as a key characteristic of scientific discourse and affords doctors, in view of their superior knowledge and supremely important activity, the primary position, namely that of arch-agent. This unidirectional, linear patterning of events represents one of the main arteries of the scientific narrative, and of doctors' power within it, and, through its availability within medical culture, provides a ready answer to a difficult question. Not only, however, would the truth of Dr S's statement most likely be hotly contested by the nurses, but it falls short of providing evidence that doctors' greater tendency to guilt is indeed warranted. In fact, it does little more than assert their greater importance, through invocation of the cause-effect storyline made available by the narrative of science and positioning doctors as sole agents of changing the 'outcome'.

Amongst the consequences of judging doctors' activities as of paramount importance is the belittling of other concerns. As such, all non-technical aspects of treating and caring for sick people, are relegated, as Good & DelVecchio-Good (1993), Mizrahi (1986), Waitzkin (1991) and Fisher (1986; 1995), amongst others, have argued in the past, at best, to irrelevance. The following extract reveals the presence of this feature of the scientific narrative in the discourse prevalent at Greenland's emergency unit:

I: So, um, what would you say are the various elements that make up working as a doctor here?

Dr S: OK, well that's easy (.) there's the doctor part, which does the medicine, there's the nurse part of the doctor that does all the nurse shit too, there's the porter part of the doctor that does that too, and there's the dressing part of the doctor that undresses and dresses the patients too.

All the tasks mentioned are performed by the doctor. However, Dr S's resentment about having to conduct the tasks she enumerates other than "the medicine" is clearly audible. And her description of those she attributes to nurses as "shit" and belittling of those she assigns to porters, merely referred to as "that," distinguish them in status from the "medicine" that, she implies, is the only worthwhile element that is real doctors' work.

Similar contempt for the concerns of others is audible, for example, in a conversation between two doctors about the efficient management of "psych patients" in the unit. A box, designated for the hospital folders of these patients, had been removed from the unit. "There were concerns about labelling," explained Dr N, a smile spreading across his face.

"Labelling is the least of my worries," Dr P responded.

"Exactly."

In this case the psychiatrist's concern with the psychological effects of singling out patients suffering from mental illnesses, and of managing them separately, is deemed trivial, and even foolish, as implied by the smile. As "the least of my worries," it contrasts directly with the matters of far more importance with which the two doctors are occupied. While narratives of science remain unstated in this extract, their presence is suggested by the importance attributed to doctors' 'concerns' through denigration of the concerns of others.

While few can deny the satisfaction we derive from the sense that our pursuits are important, or that prioritisation is an indisputable pragmatic requirement, there are unfortunate consequences arising from the preference accorded to some activities to the exclusion of all others. For one thing, as discussed extensively by a number of authors (Mishler, 1981, 1984; Mizrahi, 1986; Conrad, 1988; Good and DelVecchio-Good, 1993; Stokes, 1994; Konner, 1997; Helman, 2001; amongst others), caring activities fall squarely outside of the doctor's domain, resulting in some striking omissions and, at times, callous treatment. A patients'

physical comfort or emotional plight is seldom granted attention. And his calling for help is unlikely to earn a response. A doctor I once observed, for example, who had removed a patient's blankets to enable an examination, did not think to replace them once it was complete. Patients are also often roughly handled, as if all finesse in the performance of the doctors' core task were superfluous.

In addition to waiving the obligation to perform with finesse, the paramount status of doctors' activities offers justification for stamping out any interference with them, using, potentially, an unmonitored range of means (Szasz & Hollender, 1997). "Psych patients" are frequently silenced or immobilised by sedating them chemically or tying them up. Patients are not only "put to sleep" for threatening to attack doctors or other patients. Loud crying, singing or praying is likely to be dealt with in a similar manner and the zealously pious songs and prayers that issue from time to time from the beds around the room can be heard suddenly to dwindle away after an injection of valium. Dr N's choice of words to convey his intention to sedate a patient who had been bothering the doctors with continuous complaints and demands are revealing: "I think we must put her to sleep." "We *must*" (not "we *will*") implies the necessity of the doctors' intended action, euphemistically described as "put(ing) (the patient) to sleep" and warranted by the indisputably supreme importance of doctors' tasks.

Through the invocation of these narrative 'truths', that the doctor knows best and is engaged in a task of unparalleled importance, certain actions that might otherwise have been unthinkable are thus brought within the realm of possibility. In addition, such ease of justification in the words of Arney & Bergen (1984: p. 3), grants the medical profession the freedom to do anything, "including violating all social rules of modesty and decorum." While, as Katz (1984) argues, such actions are seldom driven by malice and may even be directed in many instances by a concern for the patients' well-being, the constructions that enable them fail to respect or even acknowledge their liberty and are liable to result in actions that, for example, override patients' objections to intrusive procedures (Wicks, 1998). On one occasion that I witnessed, a woman fiercely resisted a lumbar puncture that Dr J, suspecting that the patient might be suffering from meningitis, wanted to perform. Having abandoned the struggle to persuade her patient of the necessity for the procedure, the doctor, apparently frustrated to the point of desperation by the fruitlessness of her efforts in this regard, emerged from behind the curtain where the confrontation had taken place:

“I need someone to come help me with an LP. Get that woman onto the bed and hold her down. She doesn’t want an LP but she hasn’t got a frigging choice.”

Moments later shouts of protestation dissolved into cries of pain.

Doctor J’s choice of words to describe the conflicting wishes of doctor and patient echo those of Dr N when stating his intention to “put (his patient) to sleep.” While the doctor *needs* help to perform the procedure, the patient merely *wants* to resist it. As a requirement based on necessity, the doctor’s intention is given implicit priority and the patient’s dismissed as bloody-mindedness. No justification for the doctor’s proposed action is required. It is presumed to be imperative and is itself an unquestionable reason for overruling the patient, who simply “*hasn’t got a frigging choice*” by force of the circumstances implied (but not specified) by the doctor’s request. Interesting, too, is Doctor J’s characterisation of her patient’s intention, but not her own, as one of opposition – “She *doesn’t want an LP*” – presenting the patient’s purpose as contrary to what is obviously necessary, in this case her own decision to perform the procedure. Descriptions of patients’ intentions and actions as ones of resistance recur throughout emergency room discourse and will be discussed in greater detail with reference to the ways in which doctors suppress patients’ agency.

Narratives of masculinity

The association between medicine and masculinity is widely discussed in the literature on medical culture (see for example the work of Arney & Bergen, 1984; Mizrahi, 1986; Fisher and Groce, 1990; Cassell, 1992; DelVecchio-Good, 1995; Drife, 1998; Wicks, 1998; Erickson, 1999; amongst others) I argue in this section that traditional narratives of masculinity have a profound influence on the ways in which doctors in the emergency unit at Greenland’s hospital bring the power available to them to life, encouraging certain ways of being and acting, and prohibiting others.

It should be noted at the outset that narratives of masculinity are not available only to male doctors. A number of authors have drawn attention to the possibility for girls and women to adopt masculine identities, or to incorporate components of traditionally masculinity into their identities (see the work of authors including Paechter, 2006; Cooper, 2002; and Halberstam, 1998). Goodwin (1992), for example, discusses masculinity in terms of preferred

communicative practices, which females are able to adopt when necessary or otherwise desirable. Thus, while males may have easier and more frequent access to narratives of traditional masculinity, females are also able to employ them, and some behaviours remain 'masculine', even when performed by females (Skelton & Francis, 2002). In the words of Halberstam (1998, p.2), "What we understand as heroic masculinity has been produced by and across both male and female bodies." In terms of this viewpoint, narratives of masculinity are simply *available* within the socio-cultural context, albeit more so to some and less so to others. Within the context of the Greenland's emergency unit, women doctors' ability to employ masculine narratives is enhanced by their powerful positions and the cultural associations between both power and masculinity and medicine and masculinity.

As in the case of the narrative of science, narratives of masculinity are not explicitly stated but are audible through their characteristic patterns in the doctors' talk. The paternalistic image of the doctor as benign and all-knowing father-figure, as discussed by a number of authors writing in this field (see for example Millman, 1977; Katz, 1984), is undoubtedly supportive of the presumed authoritative status of doctors' knowledge and actions. This image is thus complicit in enabling problematic actions such as the 'easy way out' that Dr F took in telling an unquestioned lie. There are also, however, as discussed in chapter two's review of the work of authors including Wicks (1998), Fisher and Groce (1990), DelVecchio-Good (1985), Drife (1998), Mizrahi (1986), Erickson (1999), Cassell (1992) and Arney & Bergen (1984), a host of other metaphors that characterise both traditional masculinities and the practice of medicine and that are prominent in the discourse at Greenland's.

Foster, Haupt and de Beer (2005) argue that three primary 'types' can be identified within traditional discourses of masculinity: the 'military-bureaucratic' type, the 'action-man' or 'gung-ho' type and the 'warrior-hero'. Each of these types of masculine identity is, they argue, characterised by particular metaphors and associated with particular values, pursuits and actions. Foster, Haupt and de Beer's (2005) characterisation represents a useful tool for analysing some of the talk amongst doctors in the Greenland's emergency unit, which becomes, in these terms, the arena in which doctors are cast as 'gung-ho' heroes, displaying what Erickson (1999) refers to as 'medical machismo'. The 'gung-ho action man', according to Foster et al, seeks excitement, is at home in the bush, revels in contact with the enemy and might be described as an 'adrenaline junkie'. Wicks (1998) argues for the importance of

understanding the metaphors in terms of which we narrate our experiences, in that they drive current practices and provide opportunities for change. In accordance with this argument, I will show in this section how the metaphors that characterise doctors' talk in the emergency unit create the opportunity for aggressive domination and potentially for inhumane care.

Masculinity and danger

In keeping with the action-man's quest for excitement and desire for 'contact with the enemy', the emergency room is portrayed as dangerous to the doctors, enhancing their potential to establish bravado masculine identities by displaying the "balls" to which Cassell (1992) refers and their characters as "invulnerable, untiring, unafraid of death and disaster" (p. 173). It is important at this point to note that I do not intend to dismiss the doctors' allusions to the dangers of the unit as groundless. To a large extent, the hospital is genuinely unsafe. Doctors face real danger travelling to and from work at night, as many of them frequently do, along roads known for hijackings and violent crime. Many of the patients wear on their bodies the evidence that they have themselves been convicted of violent crimes, in the form of tattoos indicating membership of prison gangs. Encounters, whether medical or otherwise, with strong, tattooed men, forcibly brought to the unit by police, after displaying violent, psychotic behaviour, cannot be construed as without risk. And to cast doubt on the possibility of contracting any one of the many, largely undiagnosed and potentially contagious diseases would be foolish. Aside, therefore, from the reality of the dangers the doctors describe, my purpose is to draw attention to the ways in which their constructions of the unit as a dangerous environment resonate with the metaphors of war that authors including Cassell (1992), Mizrahi (1986), Wicks (1998) and Arney and Bergen (1984) argue is characteristic of medical culture. In so doing, I intend to show how such metaphors contribute to, and are employed in, the production of tough, masculine identities; and how these representations of danger play a part in shaping the selves that doctors become in the unit, and the behaviour that they consequently exhibit, encouraging them, for example, to "approach an operation like a battle" (Cassell, 1992, p. 173) and to view their actions in terms of combat rather than caring (Mizrahi, 1986).

The dangers that doctors attribute to the emergency unit are primarily those of contracting disease or of being assaulted. The opportunities they thereby establish for achieving impressive masculine identities are especially obvious in the case of new, junior doctors who

can be heard painting pictures of the horrors of the previous hospitals in which they worked – “There’d be weekends where there’s stab hearts, gunshots, ... (the list continued)” – as they attempt to establish their competence and belonging.

But more senior doctors, too, frequently tell stories in which the doctors’ exposure to the hazards of the unit are stated or implied. Relating the story of a patient who had waited two months after a positive TB test to be given treatment, who was now suspected of drug resistant TB, and was likely to wait another two months before receiving the appropriate medication, “meanwhile spreading it like wildfire,” Dr N remarked, “This is a perfect place for a TB outbreak. (..) It’s just a matter of time. (..) Tick (.) tick (.) tick (..). If this were the States, we’d all be wearing masks and be in isolation.” However, the air changes required to reduce the spread of airborne disease in the room, he continued, “would require a jet engine.”

And Dr P tells a story of the extreme dangers that doctors are expected to confront with unparalleled fortitude and dexterity:

Dr P: Ja (laughs) I mean six policemen came here last night-

I: Were you here last night?

Dr P: Ja- well, we were leaving, it was about four o’ clock.

I: OK.

Dr P: And they- they come up to (.) one of my colleagues who is probably like forty five kilograms, this very (.) um (.) thin girl, ok, and they come up to her, six policemen, and says, ‘Doctor, we can’t get the patient out of the van, he’s too violent. Can you go inside the van and sedate him?’ I looked at him and I said, ‘What the hell are you talking about?’ You know, you want her to go inside to sedate the patient and you are- can’t get him out cos he’s too violent! Six police officers! You know, use your head. How does that make any sense?’ (.) You know?

These examples illustrate the ways in which the dangers of the emergency unit are construed by the doctors and the opportunities for macho self-presentation that are thereby created. This point is particularly well illustrated by Dr S’s response to the unusually gruesome condition of a patient she is about to see. Striking her chest with her fist she roars, “Bring it on!” While the risk is not to herself in this instance, but to the patient, the example illustrates perfectly

the scope created by blood, gore and peril for the display of muscle. Not only, therefore, do these descriptions reflect doctors' perceptions and interpretations of their environment, they also rank amongst their efforts to define and present the desired image of themselves.

Dr N's prediction of a "TB outbreak," characterised as a time-bomb, in defence against which they should "all be wearing masks and be in isolation," implies not only the risk to which the doctors are exposed but sets the scene for the emergence of brave and powerful heroes, whose task is suitable not for a mere man but for "a jet engine." Indeed, according to Dr P, what is expected of frail lady doctors is beyond the capabilities of six burly policemen! Rather than merely reflecting the risks of work in the unit, therefore, I argue that these constructions of medical practice and of the Greenland's emergency unit as dangerous facilitate the adoption of strong, powerful identities and, on occasion, allow justification of inhumane care. In this respect, Dr P's ambiguous response to my question about Dr J's attack is intriguing:

"My god! Was she hurt?"

"Well, she was punched twice on the back!"

His reply ("Well,...") reveals an inability to state categorically that Dr J had been hurt and, simultaneously, a reluctance to deny it. I believe the ambivalence audible here is an indication of the usefulness of danger to the doctors' desired self-presentations. While Dr P paints a picture that alludes to and implies grave danger, he is unable to substantiate it, in this instance, with evidence of a real injury. Rather than simply referring to a risk he believes to exist, my argument is that doctors employ the invocation of danger in building their identities and justifying their acts of aggression. On the one hand, the presence of threat creates possibilities for masculine heroism, one of the key features of which is aggression. And on the other, it invokes the possibility of justifiable defence, thus enabling doctors to reconstruct their aggressive acts as strong and heroic, rather than inhumane. That Dr P unabashedly admits that "The psychiatric patients actually make me physically- (.) I get a rage inside me when I even think about psychiatric (patients)," is testimony to the tolerance afforded such sentiments in the unit.

Danger, action and violence

Within this context, not only do doctors narrate their treatment of patients in terms of bravado action – “You just bash them on IV, sedate them, chuck them on a bed and then ... if they don’t get well then in three days time you boot them out and just wait for them to do it again,” and, “You... just grab the sick patient, you can toss somebody else off a bed and just sort them out then.” The cultural acceptability of such ‘gung-ho’ action and indeed of aggression (as described above and by Cassell, 1992; Erickson, 1999; Mizrahi, 1986; and others), in terms of which a good doctor is required to be “aggressive and a little bit of a son-of-a-bitch” (Cassell, p. 177), enables the enactment of actual violence. In addition, beyond the discursive landscape in the unit, its practical demands and constraints encourage doctors’ involvement in the prevention of patients’ violence. And preventing violence paves the way for meting it out. Dr N, making a case for the discharge of a patient brought in by the police for manic behaviour, argues that “he’s not aggressive, he’s just breaking furniture. We’re not furniture protectors, we’re health care workers.” Statements such as this one both reflect and create what I believe to be a dangerous link between doctors (“health care workers”) and ‘real aggression’, as opposed to the mere “breaking (of) furniture.” Because the patient is not really aggressive, he is not the charge of the emergency room doctors, who are responsible only for the prevention of actual violence against persons.

The more serious displays of aggression that I witnessed in the unit tended to occur around the prevention of patients’ violence, brought within the doctors’ domain partly through lack of resources for the more appropriate management of these patients and partly through the discursive practices illustrated above that characterise doctors as responsible for curbing aggression. During the first months of my observations in the emergency room, the situation was especially difficult – lack of resources meant that potentially dangerous patients roamed the room, sometimes for days on end, and it was quite usual for the unit to hold a number of aggressive psychiatric patients at any one time. While there was always a security guard present, proximity frequently determined who intervened in a sudden, unanticipated violent outburst. The situation was in some respects improved by the addition of what became known as ‘the padded cell’, a separate room for violent “psych patients,” with a door that could only be opened from the outside, and in which they were imprisoned. What took place in that room I could only gauge from the expressions of those coming out, which were, on occasion, alarming. The mother of a patient locked in the room, for example, emerged wailing and

beseeking the other patients to help her stop the doctors from “strangling” her son. And the sound of the alarm being set off inside the room often preceded the charge of security guards, who then disappeared behind the closed door, leaving to the imagination the events within.

Sometimes, in the process of restraining aggressive patients, for example by means of a technique known as “the Greenlands take down” and, as told to me by one of the doctors, developed on the rugby field, the door is opened for doctors to become involved in the language and practice of violence:

Dr P: Two doctors, two nurses and two patients have been assaulted in the last three months by psychiatric patients.

I: Mm. Really.

Dr P: One patient sexually assaulted- Two patients sexually assaulted. (..) In the casualty. By psychiatric patients. (..) So- (..) The problem is that (.) you can- you either ignore them or hh when you with them you get almost a feral reaction, almost- Like an animalistic type of like (..) You know, take this person down, (.) you know, destroy this (.) this threat (..) as quickly as possible.

I: Can you remember the last incident?

Dr P: Name a time! (laughs) Um- I mean I was- uh- some guy who came in (..). I’ve been hit twice by psych patients. But (.) the one was bad, it was in here, hh um (.) he (.) I don’t know, he was talking or something like that, we sat him down and sedated him and he stood up, was a bit drowsy, and then comes at me and said, ‘I’m gonna f-ing shoot you, I’m gonna kill you. So I said, ‘Don’t talk to me like that,’ and then he just came at me like that. So I pulled back and (.) next- then it was no longer hh doctor – patient. Then it was like right, all best to all, lets play this game, buddy. And then the security guards were on him and (.) I mean (.) there was a full-on (sounds like: skive). Got (.) some sense beaten into him. You, know, and that’s not the way it should be done, but the point is that (.) should he ever have been allowed to take a swing at me? No. There should have been security guards there holding him. (..) Cos once you take a swing, then you change out of that mode and start changing into Rocky mode or- (laughs)

Dr P details the process whereby prevention of violence frequently leads to its enactment – “Once you take a swing then you change out of that (doctor-patient) mode and start changing into Rocky mode.” Confirming that he is not alone in his stance, he continues:

“You can- y can ask any one, you ask any doctor who’s worked in the casualty here. (.) And (.) probably, well- one of the first things he’ll say to you is (.), ‘Ja, the psych patients (.) ja, we take them down’.”

I in fact witnessed one of these incidents, in which a “psych patient” was “take(n) down” – I was sitting at the doctors’ station chatting to Dr P when another doctor came over:

“We need your help.”

Dr P got up from his chair, turning to me, his eyes glinting: “The Greenlands takedown! Come watch, if you want.”

We followed the other doctor around the corner where a scuffle had broken out involving a patient, six doctors and two security guards. In the centre was the patient, a tall, strongly built man in nothing but his underpants, screaming incoherently. Suddenly, the guards and doctors rushed simultaneously toward the man, one of the doctors tackling him so that he fell to the floor. Once on the floor, they all jumped on him, Dr S kneeling beside him, one knee pressed into his throat. Looking down at him, she asked sarcastically,

“Oh! It’s a little difficult to breathe now, is it?”

The other doctors busied themselves holding the man down by his arms and legs, Dr Q standing casually with a foot on the patient’s chest. After administering an injection of valium into the man’s arm, they successfully carried him onto a stretcher, where he continued to struggle. Having placed him face down, Dr V turned his efforts to applying the full weight of his body to the back of the man’s head, squashing his face into the hard stretcher until Dr P intervened:

“Okay, don’t actually kill him.”

When the man had been tied down, Dr P began explaining to me the details of the procedure – the patient is given a double dose of valium, in case he has developed a resistance through frequent prior sedation, all the while having his airways blocked (by the knee in his throat) to render him passive until the sedative has taken effect.

While the discursive environment renders these happenings both understandable and permissible to the participants – “You get almost a feral reaction ... You know, take this person down, (.) you know, destroy this (.) this threat (..) as quickly as possible” – a simultaneous awareness of the unacceptable nature of this behaviour lurks in Dr P’s words. Within the same sentence, Dr P both justifies his behaviour and denies his culpability – “You

get almost a feral reaction” – characterising his actions as irrational (animalistic) responses to an outside agent (the patient). Rather than planned actions, they are “feral *reactions*” that “you get” from another. And not only *I* but *you* get them, implying a universal vulnerability to these reactions that further reduces Dr P’s personal responsibility. He then reconstitutes “this person,” half a sentence later, as “this threat,” transforming what might otherwise be construed as a violent assault on a human being into the mere negation of danger, a protective rather than an aggressive act, an interpretation belied by his prior statement that “it was no longer ... doctor – patient ... it was like right ... let’s play this game, buddy.” Together with his introduction to the story, in which he sets the scene for his subsequent actions, portraying himself as the repeated victim of the threat he later sets out to destroy – “I’ve been hit twice by psych patients” – these features of Dr P’s story read like an unsolicited denial of his culpability and appear suggestive of a contrary accusation. His conclusion firmly establishes the patient’s causal responsibility for the ensuing events – “Cos once you take a swing...” – and thereby his own innocence of them, as he uncontrollably “*starts changing* into Rocky mode.” The patient’s action is portrayed as entirely unprovoked – “he *just* came at me” – and follows the benign rendition of his own action – “Don’t talk to me like that” – with the words “and then,” implying a lack of causal relationship between the doctor’s words and the patient’s attack. Dr P’s subsequent action, however, is a direct result of the patient’s coming at him – “*So* I pulled back” – again highlighting the patient’s causal responsibility and absolving himself from his own, as he portrays his deeds as *reactions*. Eventually, the patient “got (.) some sense beaten into him” by an unidentified agent.

Thus, the cultural acceptability of aggressive sentiments and violent intentions toward the patients create an atmosphere in which such attitudes become possible and permissible, setting the scene for their enactment. Events in which aggressive sentiments are physically enacted take place on a scale that ranges from rudeness to outright physical assault. The more serious incidents tend to occur during the process of controlling violent patients, brought within the doctors’ jurisdiction, partly as a consequence of inadequate facilities for their management, and partly as a product of the social construction of doctors as brave, masculine heroes. Briefly touched on in the above discussion and to be discussed further in chapter nine, the discursive environment further facilitates the subsequent justification of doctors’ violent acts, allowing doctors to blame patients for their assaults on patients and to diminish personal culpability for their aggression.

Science, masculinity and care

Of course, the discourses of science and masculinity do not operate in isolation from one another and a number of consequences for the kinds of actions in which doctors are encouraged or discouraged to participate ensue from their interaction. In this section I will explore key themes that emerge through the interaction of the narratives of science and masculinity and that, I believe, contribute to the further possibility for the violation of patients' rights.

The importance of action with impact

A number of authors (see for example the work of Millman, 1977; Hahn, 1985; Katz, 1985; Cassel, 1992; Good & DelVecchio-Good, 1993; Stokes, 1994; Konner, 1997; and Erickson, 1999, whose work is reviewed in chapter two) have discussed the cultural supremacy afforded the direct, observable results of dramatic action in medical practice, and the consequent devaluation of those actions not likely to be associated with such effects. In the words of Obholzer (1994: p173), "Doctors are caught up in the societal fantasy about their omnipotence, an unconscious social projective system in which the capacity to do heroic things is imputed to them, and they are expected to perform." Within this environment, doctors have little opportunity to earn respect and establish positive identities based on compassion or careful consideration of patients' conditions. Instead they are drawn to cases that promise immediate, direct actions and results, affording the chance to establish without doubt their scientific competence and masculine heroism. Describing the potential afforded by resuscitating a patient for doctors to "shine" through their engagement in extreme action, Dr P responds to my probes:

I: Ja. (...) So you were saying about seeing the best and the worst in people here, um-

Dr P: Mm. (clears throat)

I: Something that I'm interested in is stories of actual events. (..) Is there a particular time you can remember when you were struck by seeing the best in people?

Dr P: Well (...) it inevitably happens in (.) kind of a major, I suppose resuscitation situation (...) where (.) people just forget all about their issues and just get on with the job. (.) And (..) then you see kind of everyone working together and (.) working well and (.) you know, everything like that and (.) It doesn't happen that often but when it does happen you really see (.) that people shine...

Making a similar distinction, Dr S describes some patients as “sick” and others as “stupid”:
 “So what’s the difference between the sick patients and the stupid ones?” I asked. “I don’t get that difference.”

“Well the sick patients,” replied Dr S, “are half dead. They’re resusc patients. Then you can just get into it immediately. It’s not somebody that you’ve gotta like (.) fucking find a bed for and (.) clamber around an- you know, get yourself involved in the whole ‘there’s no bed’ crisis and all that bullshit. (.) You can just grab the sick patient, you can toss somebody else off a bed and just sort them out then. There isn’t like the whole (..) hh you do wanna see them, you wanna log roll them, but they still haven’t found a bed yet (.) and then, you know, its just (.) you sort of half- half seeing them but (.) it hasn’t quite happened yet.”

“So the resuscates are the least frustrating in terms of all those other side issues that crop up.”

“Probably, ja. And they’re the most challenging. Medically.”

“Right, ok. (...) In what way are they the most medically challenging?”

“Well because if we don’t do something then the person’s gonna die.”

“Yes. (...) And is that not the case with some of the other patients?”

“No. (...) This is an immediate thing.”

Since it is true only in terms of immediately observable cause-effect relationships that those patients not requiring resuscitation will not die if the doctors don’t “do something,” I believe the difference between “sick” and “stupid” patients refers rather to the differential opportunities they afford doctors for displaying and proving their power. Again, my intention is not to deny doctors their rightful reward for the life-saving work that they do. My aim is to point out that the narratives predominant in medical culture, in this case the traditional masculinities espoused by the doctors, in conjunction with the narrative of science, which similarly foregrounds the importance of observable cause and effect, encouraging certain actions *to the exclusion* of a great many other activities, which are classified as “bullshit.” The masculine hero / all-powerful scientist cannot be created through contemplation or caring. It the doctor’s ability to act on his environment and to produce effects, not his thoughtful approach, or displays of compassion, that confirms his potency. Thus, only those actions that highlight the doctor’s ability to “do something” that achieves “immediate” results are valued, producing an exclusive focus that, I argue, can have dangerous consequences.

As Obholzer argues, echoing the earlier comments of Paget (1988), and discussed in chapter three, (1994: p. 174), “a great deal of what goes on (in the hospital) is not about dramatic rescue but rather about facing one’s relative helplessness in the face of illness and death.” Dr R makes clear the consequences of this reality for the doctors’ identity:

“The weekend before that we had a trauma- we had a- we had a big trauma the weekend before that with head injuries and whatever. Came in in a very bad way. And we were actually able to sort of (.) not get him right but (.) get him in a stable enough position that we could send him somewhere that could get him right. (..) And those are the moments when you feel like (.) you’re doing something. (..) There’s- there’s- (laughs) there’s need for you to be here. (..) You know, it’s just- it’s very- it’s difficult now with HIV. Because (.) you get the feeling that like why do we even bother? (.) You know, these patients come in in stage four, this woman (.) that I saw now (.) stage four, they’ve got PCP⁴ pneumonia and they’ve had like reactions to all the medication they on and (.) you know, there’s really nothing you can do at that stage. It’s just (.) sit and wait and make them comfortable. And (.) 70% of the patients we’re seeing are like that. (.) Hh you know you kind of feel like why did I become a doctor if I’m gonna sit here and say, ‘Well you a right off, you a right off, you a right off?’ You know, it’s kind of- you know, it sounds harsh but that’s what’s happening. You know, you not gonna say to a patient ‘Well, you a right off,’ you gonna say, ‘Well, let’s look for some palliative care or-’ and you don’t ever feel like you’re doing something.”

In this extract, Dr R makes evident the necessity of a particular kind of result, namely clearly identifiable diversion of the course of disease, for a doctor’s action to be considered worthy of the term – “those are the moments when you feel like (.) you’re doing something.” Actions unlikely to produce these effects, for example those involved in “palliative care,” produce, instead of the positive self-evaluations associated, for example, with successful resuscitations, questions about the value of the effort spent. Unlike other actions, identifiable as the causes of immediate effects, these actions are constructed, essentially, as non-actions – “there’s really nothing you can do at that stage” – equated to “sit(ing) and wait(ing).” That the value of the doctors’ identity is bound up with their potency as defined in these terms is hinted at by Dr R’s question in response to the many patients she sees suffering from full-blown AIDS – “Why did I become a doctor”? It seems, therefore, that the doctors’ characterisation as action-men, as the all-powerful causes of their patients’ emergence from

⁴ Pneumocystis pneumonia

disease and death, places their very identities under threat every time they are faced with a reality that defies their ability to live up to this expectation.

Again, therefore, I argue that these narrative frameworks, through their foregrounding of the directly observable cause-effect sequence, and thus of dramatic action with impact, and their devaluation of caring, thoughtful or other less observably potent actions, are likely to result in inferior care through the lack of any reward for the doctors associated with such actions. This point will be discussed again in greater detail in chapter nine.

Power and emotion

The power that doctors possess is defined not only in terms of their ability to produce immediate, observable effects through dramatic action but also through their immunity to emotion. The narrative of science, with the value it places on objectivity (discussed extensively by authors reviewed in chapter two, including Cassell, 1982; Mishler 1984; Fisher 1991; Mizrahi 1986; Atkinson 1995; DeVecchio-Good and Good, 2000, 1993; Helman, 2001; Savett, 2002, Finkler, 2004; Apker & Eggly, 2004; amongst others) discourages emotional responses of any sort and glorifies indifference in the attitude of doctors. And amongst the distinguishing characteristics of the masculine hero is his immunity to the more tender emotions.

Something that struck me repeatedly during the time I spent in the emergency room was the total lack of reaction to what I found the most disturbing of events. While patients scream in pain, utter their dying sounds or cry out for help, not an eyelid flickers, not a head turns anywhere in the room, suggesting the obliteration of doctors' conscious emotional responses of which Good and DeVecchio-Good (2000) speak. During one of my first visits to the hospital a patient was dying in the resuscitation area. Dr A, who was attending to the patient, strolled over to Dr F and a nurse, who were standing over a patient in the neighbouring bed: "Can someone who can drop some adrenalin give me a hand here?"

Neither doctor nor nurse appeared to have heard the question and after a short pause Dr A asked irritably,

"Is this patient dying? Because that one is."

Apologising, Dr F and the nurse accompanied Dr A to the bed of the dying patient, where a student stood casually pumping her chest. Looking for a pulse, Dr A commented indifferently

that he was unable to find one. An intern arrived on the scene, shambling over and apologising for his tardiness:

“I got over-involved in my breakfast.”

Dr L jokingly plays on the similarity between a patient’s name and the likely outcome of his condition:

“His surname is Kaput⁵ and he’s having an MI⁶!”

When asked directly about their feelings with regard to patients’ suffering and death, the doctors’ responses are strangely barren. Dr S’s reply to my question about her feelings after a patient she was attempting to resuscitate died illustrates:

I: So how do you walk away from those events feeling?

Dr S: Well tha- I- ge- just irritated...

And in another conversation:

I: I mean I have the luxury of having to write up everything I’ve seen when I get home. It’s very therapeutic! (laughs) So I’m just wondering what you do with your emotional responses to the things that happen here.

Dr S: I dunno. (.) I suppose you speak to- er- well- we speak to colleagues about it or- Uh (.) I dunno. Ja.

While irritation struck me as an unlikely reaction to death, Dr S became quite incoherent in her attempts to offer any other response, rendering her eventual claim that “we speak to colleagues about it or-” unconvincing. Dr S further distanced herself from the emotional response I imputed to her by my question, by deviating suddenly from the “I” in her reply to the impersonal “you” and the collective “we.” While “*you...*” and “*we speak to colleagues about it,*” “I” merely “suppose” that this is the case, admitting no direct connection to the actions discussed.

Indeed, expressions of vulnerability, caring or other tender emotions are jeered at in the emergency room and cynicism and even malice advanced as the more commendable stance. Individual members of the peer group can be observed, as in Hafferty’s 1991 study, putting

⁵ Slang word for ‘finished’ that connotes finality.

⁶ Myocardial infarction.

pressure on one another to respond to events in culturally prescribed ways, and confirming their own membership of the group through engaging in what Wodak (1996) refers to as ‘rituals of talk’. Responding to my suggestion that the doctors might derive emotional support from each other, Dr S retorted, “No, I mean we don’t have big heart-to-hearts,” sneering at the possibility and highlighting the sentimental nature of what I had suggested. One of the interns, apparently commenting on his progress during the few months since I had last seen him, remarked that he was now even more “jaded” than he had been before. And Dr N comments, with reference to a disturbed and disturbing story told to me by one of the “psych patients,” that, “We don’t even listen anymore,” confirming my sense that the intern’s “jad(ing)” was proffered as a desired progression, not an unfortunate development.

Dr N’s statement, through its suggestion of doctors’ past attempts at listening to their patients and its inclusion of all those who no longer listen in the collective pronoun “we,” presents this cynical and non-empathic attitude as evidence both of experience and of belonging, and is reminiscent of Obholzer’s (1994: p. 174) rendition of the way in which junior doctors are socialised into the cynical attitude that the medical profession demands of its members: “This is how we ignore what is going on. Pretend along with us and soon you will be one of us.” Narrations of patients’ conditions are thus delivered in monotone and all descriptions of illness and suffering reduced to numbers and scientific terminology. Shifts in topic between the horrific and the mundane are a routine feature of doctors’ conversations and go unmarked by tonal modulations. Having completed her story, above, of the weekend of gunshot and other horrific abominations, Dr T asks Dr J, “So where you off to after this?” displaying not only her experience and competence in dealing with such events but also her ability to remain unaffected by them. That this emotional dearth is not confined to the doctors is confirmed as porters go by, pushing bodies on trolleys, singing on the tops of their lungs and cracking jokes like, “I’m taking him to heaven!” Illustrating the junior doctors’ admiration for such displays from their seniors, another intern tells of the approach of one of his seniors to diagnosing very sick patients’ conditions. While the intern would put considerable effort into arriving at long, complicated diagnoses involving identification of multiple, interacting conditions, the senior doctor, on consideration of the evidence, would routinely say, “I think this patient is (..) fucked.” The story implies the desirability of an attitude that not only dispenses with careful consideration but displays a total lack of empathy or caring for the patient, describing him or her dismissively as “fucked.”

Thus, rather than one amongst many characteristics of medical competence, caring acts are devalued and construed in terms diametrically opposite to the dramatic and effective action that is the hallmark of the competent doctor. In the words of one doctor, quoted by Mishler (1984), medical competence can be represented in terms of a simple choice: “Do you want to be a nice guy or a good doctor?” In practice, this discursive stance translates into a dearth of caring activities performed by the doctors.

Power, vulnerability and humour

Amongst the culturally prescribed ways of responding to such events are, as Hafferty (1991) describes, humour and ridicule, which are encouraged as desirable alternatives to expressions of distress. It was a fascinating, if somewhat disturbing, process by which my own perspective slowly changed from one of the deeply shocked observer to that of someone adequately accustomed and desensitised and with sufficient insight into the lived reality of the doctors’ experiences to be able to empathise with what I initially found wholly incomprehensible and abhorrent. After some time ‘hanging out’ in the unit, I began to be able to imagine something of what it must be like to be in the doctors’ position. It is not easy to explain how the events that take place in that room can begin to strike one as morbidly funny. But something about their overwhelming nature, whether horrific, tragic or simply bizarre, the constant frequency of their occurrence and the impossibility of meeting the unspoken expectation that the doctors should be able to “sort them out,” can create an almost irresistible sense of despairing hilarity. This unexpected and uncomfortable transformation on my part involved a shift from the aghast position of moral outrage I had initially occupied to one that included a simultaneous sympathetic identification, in which the doctors’ humour began to make intuitive sense.

This process was enabled by my slowly acquiring the ability to empathise with what I sensed the doctors experienced as the absurdity of the situation in which they found themselves, the total incongruity between it and any possible expectation, hope or dream they might have had, and the constant barrage of events that, once sufficiently distanced from the horror of it all, seemed ludicrous. A married couple with wounds from bites inflicted by each other, psychotic men prancing about in their underpants with some suggestive accessory, others emitting guffaws of laughter into their own faces reflected in the mirrors above the washbasins are all scenes that are commonplace in Greenland’s emergency unit. And amidst

it all, doctors are attempting to resuscitate, diagnose and treat very sick people. The unmanageability of these situations, coupled with the impossibly unrealistic expectations to which the doctors are subject, can, and in the context of the Greenland's emergency unit frequently do, produce a sense of hopelessness that often translates into bursts of sardonic laughter at their own inevitable defeat, rather than simply in mockery of the patients. The intern's reference to his senior's standard diagnosis – "I think this patient is (...) fucked" – Dr W's professed desire to be a mechanic, Dr V's desperate question with regard to a patient who had been dubbed "Miss Cryalot": "Has anyone got a gun? It sounds like a labour ward in here," and Dr P's suggestion, "Why don't we all just prescribe things beginning with z today?" all reveal, clearly audible beneath the laughter, a sense of pessimistic frustration or cynical futility.

The doctors' jokes therefore appear to represent a means of saying what, in terms of the narratives of science and of masculinity, is otherwise not permissible, of communicating a sense of powerlessness and even vulnerability within a framework in which power and unfeeling machismo are highly valued, and any contrary sentiment associated with weakness and inferiority.

Humour and malice

Beyond mere cynicism or lack of caring, however, doctors in the Greenland's emergency unit actually portray themselves as malevolent, creating the opportunity to act, on occasion, with animosity toward their patients – albeit under the guise of humour. For example, Dr P's sarcastic question about the state of mind of a patient approaching the doctors' station, wild-eyed and wielding a plastic bag containing what looked like half a loaf of bread and a small milk carton, invites an image of the doctors as evil game-players:

"I wonder if he's paranoid?"

[Smirks from the other doctors around the table.]

"Let's make him paranoid! (...) [Whispering and looking down at the table] They're coming to get you, they're coming after you."

Dr B, sauntering with an exaggerated ease that emphasized the inevitability of his victory and the futility of the patient's retreat, walked over to the man, who shrank back and began scurrying about in a forlorn attempt to escape.

“Come here, boet⁷, I just want to look at you.”

Using the table as a barrier between himself and the doctor, the patient attempted to ensure that they remained on opposite sides of it. When he was obscured momentarily from the doctor’s view as he scuttled behind a notice-board that stands at one end of the table, Dr B took the opportunity to initiate a mock game of hide-and-seek, peeping out animatedly from behind one and then the other side of the board, to the somewhat bored amusement of the observing doctors. Dr P joined the ‘chase’, rising heavily from his chair and ambling in the patient’s direction.

“No one wants to hurt you,” he called in a sing-song voice. “Don’t you wanna come lie down?”

At some point they were joined by two security guards, the anticipated clinching of the patient’s successful capture. Taking hold of the man’s arm, Dr B pulled him towards the bed. The four of them lifted him on and held him down while Dr P administered a sedative injection. As the valium began to take effect, the man sat up in bed, dozily rubbing his eyes. “Why am I feeling so woozy? Scratch, scratch,” laughed Dr P, sitting down again to continue writing his notes.

While done with humour and without real malice, these and similar constructions create a space for the abuse of power and the expression of pretended malice toward the patients, allowing doctors to say and do the unacceptable, and to detract from the dignity of the patient, all under the cloak of ‘good humour’. Thus, humour allows doctors to take the image of the masculine hero beyond its generally acceptable boundaries, all the while confirming the actual good nature of their acts and denying their potentially serious consequences. Dr R’s request, in response to the loud crying of a child, “Can we not give that child something for the pain? Cos I’m going to go and break his other leg soon,” Dr V’s question, “Has anyone got a gun?” and Dr Y’s suggestion that a patient be pushed out into the yard where she would “die in the rain,” rather than in his presence, become possible, and even locally acceptable, responses to the sounds of patients in pain. Dr P’s description of the ‘management’ of psychiatric patients becomes equally permissible:

“We sedate them, tie them to the bed. (.) If they (.) stop breathing (.) bonus.”

⁷ Afrikaans word for ‘brother’.

Kindness, while not entirely absent, is much less common and indeed is often met with negative sanctions. For example, Dr H arrived in the unit with some bread rolls left over from the surgeons' meeting that she intended to give to the "psych patients."

"Are they old?" asked Dr P, feigning incredulity. "Have they got salmonella?"

To Dr H's negative reply, he continued:

"Well perhaps you should put some salmonella on!" And then, more seriously, "No, man, don't give it to them – give it to the nurses rather."

I too received little reprimands for displaying what seemed to me just ordinary politenesses. After hearing a story in which I told of my difficulty in exiting a conversation with a talkative patient, and of my feeling that I had to remain involved long after I had ceased to be interested, Dr S vigorously contradicted me – "No, you didn't!" And, after I attempted to politely explain to a demanding but not seriously ill man that he was not being purposefully ignored, but was simply in a queue for the doctors' attention, Dr P admonished me: "Stop being so nice to people!"

It is my argument here that the cultural acceptability of 'black humour' and ridicule, along with the associated prohibitions against caring and 'niceness', create the possibility for the 'acceptable' transgression of ordinary social norms against the expression of aggressive desires, intentions and behaviours, and thus for the violence that is widely reported in medical practice (Mizrahi, 1986; Zaman, 2004; D'Oliveira, Diniz and Schraiber, 2002; Malterud & Thesen, 2008; Andersen, 2004).

Defences

Supporting my allusions above to the possibility that this cynical humour and these expressions of aggressive intent represent alternatives to a prevalent but unspoken sense of powerlessness and distress, there is evidence too of the doctors' employment of other defensive strategies in the emergency room talk.

Death in the doctors' narratives

For all their indifference and machismo, for example, stories of death are near impossible to obtain from doctors, who tend to delete the event from their narratives, or make only

euphemistic references to it, as found by Iedema (2007), suggesting the avoidance that Mizrahi (1986), Dreyer and Geist (1993) and Andersen (2004), amongst others, argue stems from an underlying anxiety about their competence and culpability, and from other distressing emotions, such as guilt or grief (Zagier-Roberts, 1994).

Dr G, instructing a group of junior doctors on the treatment of patients with diarrhoea, tells them, “We’ve had patients who were sent home just after rehydration and then we’ve had to fill in death certificates,” referring only to the surrounding events and leaving us to surmise the rest. Doctors shy from explicit references to death in their stories – “And then uh massive resusc ensued and then, ja, he didn’t- it wasn’t successful.” On those occasions when I persisted in prying or a doctor did spontaneously make explicit reference to a patient’s death, their remarks tended to be characterised by flippancy or humour. The following example illustrates both the doctor’s reticence, when asked for a story of death, and the subsequent offhand description that I succeeded in coaxing out of her:

I: And what about the guy who died, what happened there?

Dr S: What happened to him?

I: Ja – how did it happen?

Dr S: He- What d’you mean how did it happen?

I: Well, he came in the door and then?

Dr S: And then I don’t know, cos he’d been there for a good few hours with his adrenalin neb or something, with his upper airway obstruction, and then on handover was given that (.) what do you call it? That (inaudible) and then promptly decompensated and stopped breathing. At which point who knows? Nobody was looking at him.

In another similarly extracted story,

“We had five (.) major resuscites. CPR⁸ resuscites. And one died and the other four survived.

There was that lady. (.) Probably would have died eventually anyway. The stabbed guy who I’m sure he’s fine. (...) The high care lady who- she’s probably still alive, who knows, maybe she’s dead, and the (.) medical patient who, I dunno, he’s probably dead too, to be honest.”

⁸ Cardiopulmonary resuscitation

In the first extract, Dr S's reluctance to tell the story gives way to a callous sounding rendition that remains incomplete. Her lack of specificity in referring to the patient's "adrenalin neb or something" conveys a lack of interest in the details of the story, implying an absence of really caring. While she concedes that the patient "stopped breathing," she leaves the result of that event open to speculation – "who knows?" and, by implication, who cares? Again, however, something more emerges through the chinks in the surface of her narrative. The juxtaposition of her reluctance to refer directly to the event of the man's death with her bored and unaffected eventual narration of the story represent an uncomfortable mix that might be read as a defensive manoeuvre to protect Dr S from a more distressing emotional reaction. In view of her references throughout my interview with her to the situation in which the doctors are overburdened and therefore unable to adequately address their patients' needs – "In the ideal world there wouldn't be this many patients that one person had to see. And be responsible for" – her bitter conclusion, "who knows? Nobody was looking at him" might be read as an indictment of the working environment and simultaneous reiteration of her own lack of interest in the patient's death. Thus, while Dr S overtly presents her only reaction to a patient's death as one of boredom in the details of its occurrence, in keeping with a hard, non-emotional and masculine identity, closer inspection reveals a subtext in terms of which she is engaged in a defensive manoeuvre aimed at protecting herself from her own emotional response, thereby implying an underlying sense of vulnerability.

The second extract promises to confirm these interpretations. Here, Dr S's use of the word "probably" displays her lack of interest, this time in the outcomes of the patients' ailments and treatments, as does Dr L's joking reference to the possible outcome of Mr Kaput's MI. Some of the patients Dr S discusses are "probably still alive" and others are "probably dead" but those in both categories provoke the same response – "who knows...I dunno." This time, she conveys not only a lack of interest but also her own lack of responsibility for the outcomes – "that lady...probably would have died eventually anyway." The tone conveyed by her alternate categorisation of patients as "probably dead" and "probably still alive" creates a sense of randomness that denies the possibility that she or the other doctors could or should have done anything to change the outcome. Again, the picture she creates is one of bitter hopelessness and consequent apathy. But each time she implies the doctors' powerlessness and corresponding blamelessness, these implications resonate uncomfortably with the many

other instances in which she battles with the weight of responsibility for her patients. “Every patient there, any resuscitation that happens is my responsibility, every (.) person who dies who shouldn’t because they haven’t been seen ... it is my problem and (.) it does all reflect and (.) you know, land on my conscience.”

Not only are stories about death difficult to obtain, but when doctors do speak of death, it is often euphemistically – “he’s not going to do well,” or, as above, “he didn’t- it wasn’t successful.” This additional circumvention underlines the question raised by their reluctance to tell these stories at all – if they are indeed unaffected, why the avoidance? – suggesting that they are not as untouched as they would have us, and themselves, believe. Rather than a product of their experience and competence, the indifferent responses of the objective scientist and callous responses of the masculine hero thus appear to be a defence against distressing reactions to death, in a context within which the doctors’ power to intervene is seriously challenged, partly by fate and partly by lack of resources, and in which his construction as omnipotent renders him, if all-powerful, then also to blame for negative outcomes (Friedson, 1970; Obholzer, 1994; Speck, 1994; Mizrahi, 1986). Thus, in a narrative context within which doctors are granted absolute power, are faced with a glaring and unavoidable discrepancy between expectation and reality, and in which the above defences are readily available, what struck me initially as surprising seems in retrospect very much less so. An extract from a conversation with Dr P appears to reinforce this interpretation:

“It was a busy day (.) and she was very breathless (.) and (.) it was a quick examination and then she was- (.) you know, she was doing very badly and the decision was, ‘Ag no, she’s not gonna do well’.”

While apparently emotionally at ease with regard to the decision to terminate a patient’s treatment – “Ag, no” – the agent of the decision is curiously obscured from view – “it was a quick examination,” (performed by no one in particular) and “the decision was...” (anonymously made). In contrast to the ease with which he suggests the decision was taken and is now being narrated, Dr P evades the issue of ‘who did it?’ denying his own and possibly others’ responsibility for something he claims leaves him unperturbed but that he nevertheless continues to justify – “It was a busy day.” Repeated use of the conjunction ‘and’ to link the various events in this extract implies an interesting absence of causal sequencing.

Instead, events in this story co-exist, now obscuring causal processes when they fail to serve the purpose of bolstering the doctors' position or justifying their actions.

Thus the doctors' lack of emotional response to the pain and death of their patients, and the avoidance, callous flippancy or humour that replaces it, are made available by the role of bioscientist and the exaggerated masculinities in terms of which they structure their identities. However, their surreptitious and, most importantly, unsolicited, denial of responsibility for, or affective response in the face of, these events is suggestive not only of an objective scientist or emotionally invincible hero but of a defensive attempt to ward off distressing, unacknowledged emotions. My argument is that doctors' affirmations of their innocence and indifference are perhaps not merely reflections of their inner states, or mechanisms whereby they affirm and enhance their power. Rather, these assertions perhaps represent defensive performances whereby they attempt to protect themselves from the disconcerting implications of the discrepancies, and the self-doubt that arises in the gap between narratively-structured expectations of causal potency and heroism and the reality that falls short of opportunities for such displays. That doctors' unacknowledged emotions are likely to lead to compromised care has been argued, as discussed in chapter four, by Katz (1984), Speck (1994), Back et al. (2001) and Holman, Meyer and Davenhill (2006), and is well illustrated by many of the examples presented here.

The lack of compassion, or any emotional response, apparent in scenes such as the one presented above in which Dr A requests help from someone who can "drop some adrenalin," as well as the 'gung-ho' attitude evident in the tone of his request, is visible also in doctors' detached and frequently delayed reactions to patients' pain. Any number of administrative tasks, such as writing up notes, filling out referral forms or filing test results may take precedence over the administration of morphine to a patient in intense pain, which may occur only hours after the examination. A man lying in one of the beds was making a frightening sound with every breath. Feeling alarmed, I nervously attempted to direct the attention of the nearest doctor towards him. But my tentative question, "Is that alright?" was met by Dr F with a snigger and countered by a corresponding question – "How can it be alright?" – as she continued leafing through the list to choose her next patient. The man was dead twenty minutes later.

Again, the argument I propose is not so straightforward as to suggest that all emotional defences are bad and contribute to inhumane practices in the hospital. On the contrary, as Dartington (1994) and Cohn (1994) point out, some emotional defences are necessary to enable doctors to keep doing their work. However, as these authors, along with Obholzer (1994) and Mizrahi (1986) argue, such defences can and all too frequently do become maladaptive, producing negative behaviours rather than facilitating the continuation of positive ones. As Mizrahi (1984) observes, one of the key features of these defences is that they are not merely individual responses but are the products of shared features of medical culture. My argument here is that the excessive, and therefore maladaptive, adoption of such defences, such as the indifference or ‘manic denial’ to which Dartington, Mizrahi and Mishler et al. (1981) refer, is encouraged, in particular, by the dominance in medical culture of the narratives of science and of traditional masculinity with which this chapter is concerned.

Powerless gods

While a great deal of the talk in the emergency room serves the purpose, as described above, of boosting the doctors’ power and sense of power, and of warding off the lurking threats to their god-like masculinity that seems to teeter on the edge of an abyss of vulnerability and self-doubt, there are occasions on which the doctors can be heard openly voicing the helplessness they feel in the face of the constant stream of desperately ill patients, and the limited resources they have at their disposal for dealing with them.

Dr N, for example, describes his work as “just putting out fires” and speaks of a constant awareness of the fact that the underlying problems remain untreated and will inevitably recur. Dr O speaks of the limited power he and his colleagues have over their patients’ health outcomes, claiming, “in fact,” that “we are being paid to have no impact on health,” and alluding to the thwarted expectations, in this case of the government, who is paying them to achieve an unattainable result. And Dr P casts doubt on his father’s pride in him, suggesting its misplacement and unmasking himself as “the guy with his finger up someone’s bum at three in the morning.” These more seldom but overt statements of the doctors’ sense of powerlessness appear to verbalise and verify what most of the time lingers just beneath the surface, visible only in the form of defensive strategies against an implied but rarely stated vulnerability.

This point will be elaborated and will become clearer in the final analytic chapter, in which I deal specifically with this aspect of the doctors' narratives. Suffice it at this point to say, partly with reference to the material hinted at at various intervals throughout this chapter, and partly pre-empting that to be presented in subsequent ones, that the co-existence of this counter-discourse, in terms of which the doctors depict themselves as discredited and impotent, lends support to the argument that their bravado displays represent a defence against the more dubious personages that lurk in the shadows of their self-presentations. These spectres, threatening to reveal themselves and thereby the doctors' 'real' selves, thus shattering the illusion of their god-like power, drive the doctors to louder and more vehement assertions of their infallibility. Not only does the existence of this counter-discourse lend support to the argument offered here but it offers insight into the enormous difficulty of the position in which doctors find themselves, opening the door to a more compassionate view of what all too frequently results in the abuse of power. Without condoning the doctors' (mis)management of the contradictory discourses in which their threatened identities are formed and animated, this insight reminds us of their humanity in the face of disease and death. Not only are they paid, as Dr O points out, to save the lives and improve the health of patients, many of whom are beyond help or in need of far more than they can offer, but the enactment of the only positive identity available to them within the discursive environment depends upon the actual success of their endeavours. And the extent to which they are doomed to failure, through no fault of their own, but as a consequence, for example, of the late attendance by so many patients and the limited resources available for their treatment negates the possibility of always living up to this expectation. I believe it is this fraught position in which the doctors are caught that renders so tempting the opportunity to assert and reassert the identity of power that they feel to be crumbling between their fingers.

Infinite alternatives

It is essential to my purpose in this thesis to note that, while the influence of the narrative context discussed may be important, it is not deterministic. On the contrary, rather than merely lamenting the entrapment of doctors within this narrative frame, my aim in drawing attention to it is to highlight the possibilities for alternative ways of managing the discursive environment and responding to events. Thus, for example, in spite of their ready availability, the options that Dr F suggests, namely to lie to her patient, and that Drs P and B take up to ridicule the 'paranoid' man, are not the only ones available. Indeed, Dr A can regularly be

heard employing discourses that make way for very different actions, regularly qualifying her statements of a patient's diagnosis or her recommendations for treatment, for example, with words such as "I think" and "maybe." These and similar markers serve to highlight her opinions as such and her recommendations as open to suggestions for change, thus denying the certainty of her knowledge and making available possibilities for more negotiable action. Of a patient whose X-ray she had finished viewing, for instance, Dr A says, "I think she must go to (name of hospital)." And of another, communicating the patient's diagnosis to her colleagues, she says, "I think maybe its TB." While these 'micro-deviations' from the dominant discourse may seem insignificant, they in fact position the doctor's knowledge in a very different way, offering no pretence of certainty and allowing, in their construction, for the possibility of disagreement and for negotiated action, as well as for the requirement of justification, all of which have potentially major implications for the relative ease with which doctors can commit various actions, including inhumane ones.

A multiplicity of other factors

While I have argued, therefore, that the context of medical culture has profound, albeit not deterministic, implications for the ways in which doctors narrate their experiences and for the actions in which they can more or less justifiably engage, it is also important to note that there are no doubt many other factors that also contribute to the form that events in the Greenland's emergency unit ultimately assume. In addition to the resource constraints already mentioned as contributing factors, van der Geest and Finkler (2004) show how characteristics of the broader local contexts in which medicine is practiced are replicated in that practice, influencing its form. Most obvious within the South African social context, factors such as race and class distinctions between doctor and patient, shown by authors including Mishler (1984), Fisher (1986) and Waitzkin (1991) to be highly relevant to the quality of doctor-patient interactions in other parts of the world, almost certainly serve to inhibit the likelihood, for example, that a patient will challenge a doctor's diagnosis or any other of his pronouncements. However, doctors at the Greenland's emergency unit are from a variety of racial categories, very often the same as that of their patients. In many of the examples presented above and in the chapters to follow both doctor and patient are of the same race and gender, making for a difficult task of disentanglement that would require an analytic lens specifically attuned to these issues. To do justice to the role played by these and other sociological factors, therefore, would require analysis more complex than is warranted in

terms of the focus of this thesis, namely the features of medical culture per se that contribute to the provision of inhumane care.

Summary

This chapter has presented an understanding of the narrative context within which the doctors in the emergency unit construct and enact their identities, providing some insight into the processes whereby the violation of patients' rights become possible and justifiable. The chapter has identified themes described in previous research as prevalent in the broader medical culture and has shown how these manifest and are played out in the local context of the Greenland's emergency unit, frequently facilitating the delivery of inhumane care. For example, past research has shown that scientific knowledge is afforded superior status in medical culture (Mishler, 1984; Fisher, 1986; Mizrahi, 1986; Wodak, 1996; Helman, 2001). This analysis has illustrated the supreme status conferred on doctors in the Greenland's hospital emergency unit by their presumed possession of this superior knowledge. It has shown further how this status increases the doctors' power and diminishes the need for them to justify their actions, offering them the opportunity to pursue more pragmatic programmes, sometimes at the expense of the rights and needs of their patients. In similar vein, previous research has indicated the prioritisation of scientific activity over all other actions in medical settings (Mishler et al., 1981; Mishler, 1984; Atkinson, 1999; Good and DeVecchio-Good, 2000). And this chapter has shown how, in the context of the Greenland's emergency unit, construction of the doctors' activities as scientific endeavour obviates the need for 'superfluous' acts of caring and justifies the suppression of any perceived interference by means that, in other circumstances, would be deemed unacceptable. In addition to their obvious power to save patients' lives and relieve their pain, these aspects of the broader medical culture, within which the Greenland's emergency unit is located, afford the doctors the position of arch-agents and render them beyond question or reproach.

This chapter has further illustrated the animation, in the Greenland's emergency unit, of traditional narratives of masculinity, also identified in previous research as prevalent in medical culture (DeVecchio-Good, 1985; Mizrahi, 1986; Fisher & Groce, 1990; Cassell, 1992; Erickson, 1999).. Through the features of these narratives, doctors are transformed from '*götter in weiss*' into action-men and even military style heroes. The analysis shows how the Greenland's doctors draw on these narratives, exaggerating their bravado identities

and portraying the unit as one fraught with danger and opportunity for daring. Promoting the avoidance of tender responses to the suffering with which they must deal, and offering the chance, through masterful action, to establish and maintain powerful identities, metaphors of masculinity encourage the doctors to respond, all too often, with callous humour or brute force.

The façade thus created is not, however, without cracks. The self-doubt described in previous research (Fox, 1957; Mizrahi, 1984; Katz, 1984; Atkinson, 1995) as inherent to the medical identity can be heard between the lines and words of the Greenland doctors' discourse of ostensible power. As doctors attempt to perform dramatic cures under difficult, even hopeless conditions, they simultaneously voice fears of failure, vulnerability and powerlessness, fuelling their need to prove their power, sometimes through displays of aggressive dominance.

CHAPTER EIGHT

A MUTUALLY ANTAGONISTIC SYMBIOSIS: THE RELATIVE NATURE OF DOCTORS' AND PATIENTS' IDENTITIES

The analysis that I present in this chapter is based largely on the premise that identity is constructed in interpersonal interaction and that it is relational in nature, in keeping with Bakhtin's theory of language and consciousness, as detailed in chapter six. It is further based on that assumption fundamental to the ethnographic approach employed in this thesis, namely that people's identities and actions make sense in terms of the meaning-contexts in which they occur (Atkinson & Pugsley, 2005). The previous chapter explores the 'grand narratives' that dominate life in the emergency room at Greenlands hospital, depicting the discursive landscape in which the events in the unit take place. This chapter offers an analysis of the positions that doctors and patients occupy relative to one another within this narratively structured context, and of their implications for the relationships that develop between them and for the possibilities for action available to them. In this chapter I therefore discuss the ways in which doctors build their identities relative to those they attribute to their patients, and in response to the relevant features of medical culture, as identified by previous work. I then propose an argument for the ways in which these identities depend upon and represent the breeding grounds for the unbalanced power that doctors hold within the unit, enabling and justifying acts of inhumane care.

Us and them

In keeping with Zagier-Roberts's (1994) observation that a group's identity always involves its being alternative to some other group, the doctors in the emergency unit at Greenlands hospital differentiate themselves from others, producing Fisher's (1986) 'two-place logic', within which everyone is defined as either 'doctor' or 'not doctor', and emphasising both the distinction between 'us' and 'them' and the bond between members of their own group. After briefly introducing the production and maintenance of firm

boundaries around the group of emergency room doctors, I explore in this section the construction of opposite and even antagonistic identities for doctors and patients.

The firm bounds of collegiality

The solidarity that exists between members of the medical profession has been widely noted (see for example the work of Millman, 1977; Mishler et al, 1981; Mizrahi, 1986; Paget, 1988; Fox, 1989; Wodak, 1996; Apker & Eggly, 2004). Indeed, collegiality is identified by Rosenthal (1999) as one of the ‘twin pillars’ of medical culture, thus representing a core element of the meaning-context in terms of which identities and relationships are defined and actions taken. Amongst the key features of this collegiality, as enacted and produced by the doctors within the Greenlands emergency unit, is the definition of airtight boundaries around the doctors’ group. The boundaries of the emergency unit doctors’ group are impermeable not only to patients but to anyone outside of its demarcations. As discussed in my narration of the research process in chapter six, I was struck by the impenetrability of this social group and felt it acutely in the early days of my presence at the hospital. The extent of my exclusion was such that not a word of greeting, not a conversational remark nor even a glimmer of friendly recognition was extended to me. I would arrive in the unit and find that my attempts at friendly hellos were met with averted eyes and failures to respond. Neither was my presence acknowledged by those who knew me, nor questioned by those unfamiliar with my purpose. None of the ordinary means of social access seemed available and I battled for weeks to attain even the first promises of inclusion. Not only I but other ‘non-doctors’, too, were alienated from the doctors, through conversational means (as detailed by authors such as Wodak, 1996, and Erickson, 1999, in his analysis of the use of ellipsis as a means of demarcating group boundaries within medical culture), as well as through other features of the social environment, such as its spatial divisions (see the work of Muller, 1999).

While my focus in this thesis is on the contribution of talk, specifically, to the facilitation of identities and actions in the emergency unit, a brief description of its spatial

arrangements will serve to depict the physical setting in which the ensuing talk occurs, echoing Muller's (1999) analysis of the ways in which relationships of exclusion and belonging are created through spatial demarcations. Within the unit, doctors occupy the central space, congregating around the doctors' station, a long table and chairs in the middle of the room. Seated at this table, they face each other with their backs to the other occupants. The nurses' station is located in a corner of the unit and the patients lie in beds and sit or sprawl on benches around the perimeter. The practical reasons for the arrangement described are clear. The doctors' central position facilitates maximum surveillance of patients, who are most easily visible laid out, as they are, around the edges of the room, and who, from this position, present minimal obstruction to medical activity. Any spatial arrangement, however, whatever its nature, acquires meaning through our engagement with it and activity within it. Thus, the spatial demarcations, adherence to and enforcement of them, not only serve their intended (practical) purposes but contribute to the social separation of doctors and others and to the possibilities (and prohibitions) for action within them. In addition to these spatial dimensions, a further material circumstance should not be overlooked – the tangibly unavoidable distinction between doctors and patients in terms of which one is fit and able and the other incapacitated by illness, further sets them apart and renders them powerful and dependent, respectively.

The wall thus erected between doctors and patients is reflected and maintained in multiple ways. Doctors' references to their patients frequently take the form of referrals to "*that patient*," "they" and "them," linguistically distancing the speaking doctor from the patient of whom he is speaking, and reinforcing constructions of 'us' and 'others'. Talking to his junior colleagues about the administration of enalapril⁹, Dr G tells them, "One dose is not gonna kill them. Ok?...So- so what if you did it? It's not like you giving them potassium. (..) So you just give it to them."

⁹ A drug for the treatment of high blood pressure

Later, speaking of confusing cases, he tells his juniors again, “In the beginning you have a reason to admit them...Now, the next morning they getting better and you don’t know what is going on with them. (..) That tells you you can’t actually send them home.”

In both extracts the doctor speaks of patients as members of a broad category of people who are not ‘us’. ‘They’ are thus brought into being as a coherent entity, the same as each other and different from ourselves. The existence of such a group enables a set of associated constructions, in terms of which doctors establish and confirm the unity of their own group, referring to themselves and each other as “we” and “us.” Again, these constructions highlight the dialogical nature of their own and their patients’ identities, a clearly defined ‘other’ enhancing the definition of a more coherent self. The doctors are brought closer together, as they stand in contrast to the throng of others and a strong sense of camaraderie develops between them, reflecting and enhancing the strength of their group identity and mutual identification.

Once again, humour plays a key part. The jokes and other humorous comments illustrated throughout this thesis represent the medium through which doctors narrate much of their experience. These communications appear to form a key mechanism by which ‘we’ recognise ‘us’, as it was through sharing in their humour that I was eventually able to penetrate the heavily guarded boundaries of the doctors’ group. As discussed in chapter six, the recognition I eventually achieved from the doctors began when I started laughing at their jokes. The doctors’ cynical humour thus affirms their identities as strong, masculine heroes, unaffected by sentimental responses to horror, tragedy and the like. Simultaneously, it produces a sense of mutual empathy and identification between speaker and hearer, the latter confirming the affinity of his experience and person by making regular similar remarks, which reassure the speaker that he is in good company.

Us vs. them

The Greenland emergency unit's doctors thus differentiate and define themselves in relation to everyone outside of the closed borders of their group. However, it was that aspect of the relationship between them and their patients, specifically, that struck me most vividly and that bears most relevance for an explanation of inhumane care: namely, its antagonistic nature, in terms of which they are constituted in not just different but perpetually opposing positions. This aspect of the relationship between doctors and patients has been dealt with fairly extensively in the literature on medical culture, most notably in terms of the binary construction of medical knowledge and the patients' subjective experience (Mishler, 1981; Helman, 2001), characterised in much of the literature as a confrontation between conflicting agendas (Francis & Hester, 2004; Atkinson, 1995; Mishler, 1984; Hogarth & Marks, 1998; Kirkmayer, 2000; Heritage & Maynard, 2006). Not only are the polarities between them defined in terms of broad, socially structured dimensions, such as class, culture and level of education. Their characterisation within the details of the emergency room's local culture produces figures that exist, as argued by Katz (1984) and Dreyer and Geist (1993) with reference to other medical settings, in opposition to one another in almost every respect and in fact in conflict:

“At least that patient's calmed down – it's like revenge of the annoying patients here today!”

In addition to this and other expressions of the doctors' frustration and feelings of victimisation by their patients, the antagonism in the relationships between doctors and patients is audible in the variety of terms doctors use to describe them – “helicopters” who “circl(e) us,” “crazies” and “bastards” are by no means complimentary and manifest a hostility between the two parties. Patients, too, can be heard occasionally referring to their doctors as “perdedokters,¹⁰” a similarly unflattering term implying their fitness only to treat animals.

Dr P provides insight into the resentment with which doctors often regard their patients:

¹⁰Afrikaans word for veterinary surgeons

“And you’re cross with someone for moaning about their pain because you’re busy with something and don’t irritate.”

He goes on to describe his and his colleagues’ responses to the paramedics who bring the patients to the hospital, providing an explanation for the animosity with which they are received:

“I think the thing is here it’s like, oh god, not another patient. You know? Ahhh I cannot handle another patient right now. So you almost ignore them and (.) pretend that they’re not there and (.) etcetera etcetera. And blah blah blah hh ... But they (the paramedics) doing their job, they not doing it to spite you. (.) But that’s how you feel – you’re like, god dammit, you’re bringing me this patient, you bastard! You wanna ruin my life because hh (.) you know, I already got (.) 25 patients here now and (.) I mean people are sleeping on the floor and now you bring in another one, well good luck finding a stretcher (inaudible)! You know? That’ll show you! You know?”

It thus seems that the overload that doctors experience produces a sense of victimisation. And the sense of being overwhelmed produces anger toward those who submit the unmanageable demands. Perhaps resonant with Wodak’s (1996) suggestion that ‘medical moaning and grumbling’ represents a means of producing and affirming group identity, the relationship between between doctors and patients seems transformed from one in which the doctors’ role is to help their patients into one in which doctors become their patients’ victims and endeavour to protect themselves from them. Comments such as the handy hint Dr P gave a student – “Here’s a tip – if you want to survive in this unit, never speak to the patients,” and Dr L’s statement, as she avoided the medical holding area, that, “I’m not going in there to face that crew,” illustrate the point and show how doctors become more and more guarded against what they perceive as the threat posed by patients, who have become in their constructions a menacing *crew*, rather than merely a queue of sick individuals, thus complicating and exaggerating the distance and distinction between them.

Doctors, patients and personhood

Patienthood and subjectivity

In a manner related to, and exacerbating, the difference between doctors' constructions of themselves and their patients, the emergency room doctors in fact fail to acknowledge their patients as subjects. Eliminating patients' personal identities in their talk through a variety of means, the Greenland's emergency unit's doctors enact the historically-rooted disappearance of the patient as subject (Mishler et al., 1981; Hogarth & Marks, 1998; Rothman, 2003), or in Foucault's terms, of the 'sick man' (Hak, 1999).

Probably most striking in the emergency unit doctors' talk about their patients is their almost exclusive reference to them merely as 'patients', almost never calling them by name or referring to them in more particularising terms. Doctors, in fact, tend not to distinguish between one patient and another, beyond references to the diseases that differentiate them. Recalling Mishler's (2005: p. 449) argument with reference to the notion of a 'patient' that "there is always a person whose complexity and fullness is not captured by this characterisation," I argue that such extensive use of this generic term translates in emergency room discourse into 'not us' and contributes to the repression of more personal, subjective identities, as illustrated in the following excerpts from emergency room talk. Dr T introduces a woman to her colleagues on the ward round: "This patient is a thirty-seven year old woman, hyperglycaemic¹¹ with positive TB, RVD¹² and red blood cell count of 4+."

Dr J relates the sequence of events since a woman's arrival at the hospital:

"This patient came in..."

And Dr A informs her colleagues of a woman's need to be admitted:

"This patient is for admission."

¹¹¹ Having a high blood glucose level

¹² Retroviral drug – an encoded reference to HIV intended to protect the patients' privacy.

In addition to the labelling of patients as ‘patients’, doctors tend to describe them in very limited terms (Donnelly, 1997), such as in terms of the numbers produced by laboratory tests (Atkinson, 1995) or simply as embodiments of the diseases from which they suffer (Helman, 2001). Dr T (above) continues her description of the patient in question solely in terms of her test results – the woman’s only characteristics relevant to herself and her colleagues. Similar descriptions abound. But doctors go further than merely neglecting to point out their patients ‘superfluous’ characteristics, actually equating the person with the disease itself. Requesting advice from the psychiatrist on duty, Dr J refers to her patient as the embodiment of her condition:

“This patient came in- (.) she’s a drug induced psychosis so we don’t need to keep her, hey?”

In Dr J’s description “this patient” *is* “a drug induced psychosis,” rather than a person suffering from one. A person who has been stabbed in the heart is a “stab heart,” in the face a “stab face” and in the abdomen a “stab abdomen.” Someone known to be suffering from chronic obstructive pulmonary disease is a “known COPD” and a person who has suffered a heart attack is an “MI.”¹³ Patients are thus reduced to the “site(s) of specific disease entities to be detected and evaluated by the doctor independently of the patient” (Mishler et al., 1981: p. 224).

The fading of patients’ individual faces into an indistinguishable sea is further aided, as noted by Goffman (1961) and later by Helman (2001), by their attirement in hospital garb. Patients are immediately identifiable as such (and therefore distinguishable from everyone else) by the fact that they wear pale blue regulation hospital gowns or are covered by hospital blankets of the same colour. In the words of Dr T, “I can’t recognise any of them because they’re all wrapped in blankets.” Each person thus appears as an anonymous blue entity, more often than not silent, slumped in a chair or lying on one of the beds – ‘patients’, rather than people like ‘us’.

¹³ Myocardial infarction.

Doctors also frequently refer to their patients as “this one” or “that one,” expressing and reinforcing their construction as specimens of a group rather than as individual subjects. For example, “This one is not seen yet,” or “that one is for ward two.” This deletion of patients’ individual subjectivities is further manifest in the not uncommon but nevertheless surprising absence of possessive adjectives in the doctors’ talk about their patients – “What’s *the* iron level?” instead of “What’s *her* iron level?” – denying the existence of the person whose iron level is in question. Dr A’s question, “And is able to walk now?” compromises conventional grammar in favour of a subjectless construction. And Dr M’s remark that, “Maybe it’s one of Dr R’s patients,” speaks volumes through its use of the word “it” to describe a person. A patient’s comment to me about her failure to engage her doctor’s attention in attempting to acquire information about her diagnosis is perhaps revealing of the patients’ experience of these omissions: “It’s like she’s seeing us and she’s not seeing us.”

The subjective experience of objects

One of the consequences of the deletion of patients’ subjectivities is the denial of their personal experiences. This consequence of the objectification of patients is discussed extensively in the literature, as reviewed in chapter two, by authors including Mishler (1984), who argues that the negation of patients’ subjective experience in fact precludes the possibility for humane care, which depends upon the centrality of the patient’s experience to the medical encounter.

Not only is there sparse mention in emergency room talk of the physical or emotional discomfort and distress of the patients. There is little recognition, in fact, of their lifeworlds at all. Doctors’ and patients’ conversations with one another are structured such that there is small possibility for patients’ experiences to emerge, illustrating their successful application of the techniques that DeVecchio and Good (1993; 2000), amongst others (Mizrahi, 1986; Fisher, 1986; Apker & Eggly, 2004) argue are taught in medical schools to enable doctors to elicit only ‘medically important’ information. Generally, their conversations take the form of questions or instructions from the doctor and responses by the patient, doctors retaining control over the topic for discussion. The

doctors tend to ask their questions in closed-ended format, asking for little more than single pieces of information. A patient had fallen on the stump of her recently amputated leg, leading to an infection in the wound. Attempting to decide on the best course of action for treatment and subsequent management of the woman's rehabilitation, Dr G asked,

"Who do you live with?"

"I live," she replied, "with my two sons and-" cut short as soon as the doctor had acquired sufficient information:

"Ok. So there's someone to help you."

Another patient was suffering from extreme anxiety, raising the possibility that the physiological symptoms with which she presented might be psychological in origin.

"Are you experiencing stress at home?" asked her doctor.

"Yes because they smoke buttons¹⁴ in the house and they-"

"Ok, so there is stress," came the reply, again cutting her short and indicating the lack of need for an elaboration.

And of a patient who had attempted suicide, Dr G asked,

"When did you take the pills?"

"Day before yesterday."

"What time the day before yesterday?"

"Morning."

"OK. Paracetamol levels and give him vitamin K."

Again, the doctor makes no attempt to inquire after or acknowledge the possible reasons for the suicide attempt or the circumstances that led to the patient's desperate action. His questions are concerned solely with determining the length of time that has elapsed since the patient ingested the pills so that he can make his decision regarding medication, as he edits out the patient's story, transforming his illness into a disease (Savett, 2002) and reinforcing the clear distinction within medical culture between the patient's physical

¹⁴ Mandrax

distress and his life context and emotions (Cassell, 1982). These extracts thus illustrate what authors including Mishler (1984), Atkinson (1995), Hogarth and Marks (1998), Kirkmayer (2000) and Francis and Hester (2004) have characterised as a confrontation between the medical and the patient's perspective, in terms of which doctors pursue their biomedical agendas and patients attempt to present their illnesses in terms of their personal life circumstances and emotions (Finkler, 2004; Heritage & Maynard, 2006).

Not only do doctors make no attempt to elicit information from their patients that might give insight into their subjective experiences, and indeed cut them short when they offer it, but they discourage each other from the same. Dr N's comment that "We don't even listen anymore," discussed in the previous chapter, illustrates the construction of the practice of listening as naive and therefore stigmatized. Doctors can further be heard warning each other against the dangers of talking and listening to their patients. Dr T asks her colleague,

"Is that the guy that you spoke to before?"

"No."

"Well don't." she advised. "He'll tell you all about his disciples."

As previously discussed, Dr P jokingly instructs a student,

"Here's a tip- if you want to survive in this unit, never speak to the patients."

And Dr F proudly tells me of her success in avoiding communication with one of her patients. Having exerted considerable effort in avoiding meeting the gaze of the patient, who was waiting anxiously for test results, she had eventually been compelled to respond to her:

"I am still waiting for the blood results'," she reported having said. "I just kept walking. I didn't even give her a chance to say anything."

On those occasions when a patient foists her perspective on an inadequately defended doctor, the doctors' response is often to belittle what has been said, rendering it inconsequential and even objectionable: "Is she enlightening you on her issues?" asks Dr

Q of Dr R, implying the unimportance of anything the patient in question might have said.

And a group of doctors gathered at the doctors' station discuss the experience of two patients, a husband and wife, who had injured each other during an argument:

Dr 1: Her husband bit her on the cheek.

Dr2: But she did stab him in return.

Dr3: I'm not sure which one came first – the stab or the bite.

Dr2: (laughs) She stabbed her husband and he in return bit her – or I don't know which came first.

All: (Smiles and laughter.)

In the first quote Dr Q expresses disdain for the content of the patient's story, without even knowing what it is, referring sarcastically to "her issues" and ironically to Dr R's knowledge thereof as "enlightenment." In the second example the doctors joke and laugh about what must have happened between the quarrelling husband and wife, denying its possible rational explanation as well as its relevance, through their lack of concern as to the precise sequence of events. And when a patient's subjective experience is the presenting problem itself, necessitating the doctors' attention, it is discussed in terms that give little insight into its nature, indeed mocking the patient's perspective, as in, "Is he still loopy?" or describing it in terms that refer only to its outward manifestation – "She's very tearful" – thus capturing only what is objectively observable (Mishler, 1984) and giving voice to the fundamental scientific assumption that anything that is real can be seen (Arney and Bergen, 1984).

The doctors' constructions alone, however, cannot be held responsible for the suppression of the patients' lifeworlds in the emergency unit. The fact that the majority of patients are too ill to be capable of or interested in conversation contributes in large part to the invisibility of their subjective worlds. In addition, many of the patients perceive their doctors, perhaps correctly, as uninterested in their ailments and circumstances beyond those directly relevant to diagnosis and treatment. For example, a man told me

immediately after the round had left his bed that he had not eaten since the previous day and was hungry. In response to my suggestion that he tell one of the doctors or nurses, he replied dejectedly that, “These doctors, they don’t worry with things like that.” The sister of a woman Dr P had (mis)diagnosed as having suffered a “big stroke,” after bursting into tears as soon as the doctor had left the bed, explained to me that, “I can’t before the doctor.” And a woman who had stopped taking her TB medication prematurely, due to her belief that a curse placed on her by her neighbour, and not a bacterium, was responsible for her illness, illustrates her awareness of and responsiveness to the belief prevalent in medical culture and identified by Fisher (1991), namely that the patient’s perspective is irrelevant to the diagnosis and treatment of disease. The woman did not intend to explain her reasoning to her doctor as “he will not believe me anyway,” precluding the possibility of negotiation on the subject of resuming treatment with this particular patient. Not only obstructing communication about the management of this patient’s particular case, her silence further obstructs the doctors’ view of the cultural barriers to effective treatment presented by the context within which they work, thus contributing to the maintenance of medical ‘blindness’ to patients’ subjective experiences more generally.

As argued by Lorber (1975), as well as by Goffman (1961) and Mishler et al. (1981), this denial of the patient as an active human subject plays an important role in the delivery of medical care, enhancing efficiency and creating a distance between doctor and patient that makes it easier for the doctor to carry out invasive or potentially mutually distressing procedures. Once again, however, I argue, along with authors including Goffman (1961), Mishler et al. (1981), Mishler (1984), Clark and Mishler (1992), Katz (1984), Mizrahi (1986), Fisher (1986), Lewhinsohn (1998), Helman (2001) and Savett (2002), that this process has simultaneous damaging consequences, both for patients’ dignity and for the more concrete processes and outcomes of healthcare delivery.

Amongst the effects of the objectification of patients is reinforcement of the supremacy of the doctors’ position, effectively rendering them the only people in the room. As such, patients’ needs, acts and intentions are subsumed under those of the doctors, disappearing

from the realm of consideration. The following examples illustrate the shift in priorities made possible by the objectification of patients and concomitant construction of doctors as the only human subjects present in their interactions. Rather than identifying their patients' needs, the doctors construct these in terms of their own:

"I need her to go for an X-ray."

"She needs to do another gas for me because I'm not going to be happy."

And,

"Can we not give that child something for the pain? Cos I'm going to go and break his other leg soon."

Similarly, actions and events that are in conflict with what we might suppose are the patients' needs are constructed as thwarting only the interests of their doctors. Examples of doctors' discussions of the negative consequences, or possible consequences, of their erroneous actions are particularly illustrative, focusing solely on the results for themselves and neglecting to mention what might be presumed to be the far greater effects on their patients. One afternoon, a discussion was being held in the unit, primarily between the more senior members of staff from around the hospital. There was some consternation about a baby who had died before being attended by a doctor, as well as about a man who had presented with haemoptesis¹⁵ and had been told to go home and attend a clinic the following morning. Another man with head injuries had been sent to forensics "still bleeding." Dr N lectured the junior doctors on the importance of treating a life-threatening injury even if it meant losing evidence of a crime in the process.

Apparently, the doctor who had seen the man had not recorded it in his notes:

"So then you are not covered. You need to keep a record of at what time you did what. What was the status of the patient when you saw him?"

The same applied to the patient with haemoptesis:

"Haemoptesis is always an emergency. What's gonna happen if the patient comes back and says, 'That's the doctor'. Then you will be liable."

¹⁵ Bleeding of the lung

And, discussing the possible transfer of a patient to another hospital, Dr N said more humorously,

“I don’t want to send her in case she dies in the ambulance. And it looks quite bad (glancing at the patient). (..) That wouldn’t look good – sending a dead patient to another hospital (laughs).”

In all the above stories a person’s life is at stake. However, the risk that is mentioned is not that of the patient’s death in itself, but rather the subsequent consequences thereof for the doctor. Having deleted his subjectivity, the patient’s death becomes incidental, relegated to the status of a preceding event and merely setting the scene for a risk of litigation or damage to the reputation of the doctor.

Subjectivity and agency

The capacity of objects for action

A direct consequence of the objectification of patients is the resulting extinction of their capacity to act. Only a subject can be an agent. An object is merely acted upon. These constructions therefore have interesting and enlightening consequences for the nature of patients’ oppression, as constructed within the doctors’ narrative framework. Rather than denying their patients the capacity to act, the doctors merely deal with them in accordance with their inherent incapacity to do so. The doctors’ conduct in this regard is now absolved from its moral implications and, in the process, the job of oppressing the patients is made all the easier – the work is done *before* the patient acts and, thereafter, undesired action by the patient can be labelled ‘insubordination’.

Patients are rarely given the opportunity to act within the doctors’ discursive constructions, decisions about their treatment, progress through the hospital, discharge or subsequent management being expressed in terms of what the doctor(s) will do *to* the patient:

“We’ve decided to med reg¹⁶ her.”

“We are going to keep you here for a few days.”

“We’re going to discharge you.”

In none of these constructions is any action on the part of the patient required, their doctors assuming the role of sole agent in fulfilment of the relevant plan. Any actions on the part of the patients are absorbed within the doctors’ stories, the doctors becoming the ultimate agents of anything the patients might say or do and the patients positioned as acted upon or merely reactive to their doctors.

“If you wanted to give me a picture of what it is that you do when you attend to your patients- (...) How would you describe it?” I asked Dr S.

“ (...) I dunno,” she replied. “You find their name, you shout it out, you (.) go through m-medical holding, go look around shouting it out until you find them, then you drag them along until you find somewhere you can examine them (.) and then (.) you deliver them, sort them out, and (.) look for a few things and (.) send them off to X-ray and then hh try to remember to look at them later (laughs).”

While my question overtly asks the doctor for a description of her actions, her reply describes acts that involve only one person, giving no hint of a process of interaction, negotiation or even of the patient’s active cooperation. She simply “Shout(s) out” the patient’s name until *she* finds *him*, making no allowance for the possibility, and actual likelihood, that he will make himself known to her on hearing his name. She then “drags” him, who has now become an object with no contribution to make to its own movement, “examine(s)” him, “deliver(s)” him and “sort(s)” him out, entirely by her own effort and unaided by any cooperation, less still initiative, from him.

In other instances, when the doctors do acknowledge their patients’ cooperation, their references in this regard tend to depict the patients’ actions as instigated by themselves for their own benefit:

“Lie down for me.”

¹⁶ Send her to the medical registrar for admission

“Smile for me.”

“What I want you to do for me...”

While these instructions imply the doctors’ need for willing cooperation from their patients, overtly requesting that the patients perform some action, the disguise is thin and falls quickly away when immediate compliance is not forthcoming. A patient, growing tired of the neurological tests her doctor was attempting to administer, provoked a more definite command from her doctor when she failed at first to comply with her request: “No! No! You have to do it because we don’t know what is wrong with you!”

In still other instances, the doctors position themselves not just as the intent behind the act, but indeed as the acting subjects in sentences in which their patients perform for them – “let’s see you walk.” The doctors are the subjects who will *see* the patient, the object, perform an action directed by themselves. And in still other instances, they position themselves as the actual (hidden) agents of their patients’ experiences – “Why am I feeling so woozy? Scratch, scratch.” The audience knows, in this case, that the patient is feeling “so woozy” because of an injection of valium that the doctor has administered. And a passing doctor, unaware of the conversation or the preceding events, on seeing the heavily sedated man, assumes as much: “Have you done some work there?”

When patients are positioned as causally responsible for an action or event their responsibility as such is construed in passive terms. A woman who became irate at the delay of her discharge, and who was anxious to return home to her very young baby, was described by Dr N as “losing the plot,” denying her intent, as she *loses* the plot rather than throwing it away in anger. Alternatively, doctors offer their patients permission to act, or even command them to do so, connoting secondary status to the patient and positioning themselves as the intention and ultimate drive behind fulfilment of the action: “OK, we’ll give you some pain tablets and another antibiotic, then we going to see. (.) Then if it’s not better we’ll let you come in.”

“You can go home after you’ve been to the pharmacy to get your medication.”

“Go sit down!”

And even,

“Sit down and wait!”

In giving their permission for their patients to act, doctors presume their patients’ dependency on themselves for their capacity as agents. And in commanding them, doctors take for themselves the role of ultimate agents of their patients’ actions, which become, essentially, *reactive* to their will.

In turn, patients cooperate by asking their doctors’ permission to act, often in ways that confirm their own infantilisation through this process. A woman in her mid thirties asked Dr R in a whining tone,

“Please let me go home!”

“No!” shouted Dr R. “Go and sit down and wait for your blood results!”

“Please!” begged the woman.

“Just go and sit down and stop irritating me!”

When patients transgress their doctors’ orders or act without their consent, rather than constructing these events as wilfully designed actions, the doctors construe them in ways that continue to deny their patients’ agency. Instead of “Don’t walk around,” Dr G tells his patient, “You can’t walk around,” denying her capacity to walk, rather than the acceptability of her doing so. Alternatively, when patients act in ways that are contrary to their doctors’ wishes, their actions are constructed as ‘anti-actions’. A patient who does not comply with his doctors’ orders is ‘noncompliant’. One who fails (or chooses not) to take his medication ‘defaults’. And one who will not accept a recommended procedure ‘refuses’. In each case, the action is constructed as an act *against* something else, rather than simply in its own right. These actions thus exist only in relation (and indeed in antithesis) to other actions by the doctors, who remain the defining characters and the ones on whom their patients’ limited agency depends.

Not only are patients’ actions construed as deviations or oppositions but the acting patients themselves are ascribed deviant identities – “We got a walker!” A man who had

not taken the medication prescribed for his high blood pressure was labelled repeatedly in his folder as “HBP¹⁷ med defaulter,” transforming him from a man with reasons for his actions into a deviant who, by definition, goes against his doctors’ orders – he *is* a ‘defaulter’. The man’s story as told to me in my conversation with him is revealing of the vast discrepancy between this construction and other possible interpretations of his behaviour. A chronically ill individual, he was unable to work and had no family to support him. From his dress and general appearance it was apparent that he was very poor. His parents were both dead, his sister was born without legs and his brother was looking after his own as well as this man’s children and could therefore give him no further assistance. Since the medication he required was only available at two tertiary hospitals, and since he lived near neither and transport was routinely unaffordable, it was frequently impossible for him to collect his medication. In light of his story the label ‘defaulter’ seems somewhat oversimplified and seems to serve the purpose, rather than simply representing the facts, that Millman (1977) and Dreyer and Geist (1993) identify as served by the stigmatizing labels in terms of which patients are frequently described, namely to render them incapable of rational action and thus justify and perpetuate their ‘ineligibility’ for agency and their consequent treatment as objects.

As in the case of the production or invocation of any deviant identity, a moral dimension is involved, in terms of which ‘good’ patients recognise their ignorance and powerlessness, accept institutional procedures without question, provide the required information, take their medication correctly and so on, and those patients who do not accept the doctors’ absolute authority are characterised as ‘bad’ (Lorber, 1975; Fisher & Groce, 1985; Armstrong, 2002; and Andersen, 2004). The moral implications of the above interpretations of patients’ actions are well illustrated by the example provided by a young woman who had left the hospital against her doctors’ recommendations, and subsequently returned. In her words, she had made a “vokop.”¹⁸ “But I apologised to the doctors and I hope they will forgive me,” she said, subdued by the intensity of her pain, and invoking constructions both of her actions as morally bad and of the doctors as in a

¹⁷ High blood pressure

¹⁸ Fuck up (Afrikaans)

position to judge and, hopefully, to forgive. She thus takes the implications of her actions beyond the mere transgression of norms, invoking characters for herself and her doctors that are ‘bad’ and ‘good’, respectively.

As evident in this story, and pointed out by authors including Fisher (1986), Dreyer & Geist (1993), Gill (1998), Perakyla (2002) and Heath (2006), who argue that patients are complicit in producing their own passivity, doctors are not alone in producing the status quo. Doctors and patients both occupy the same social world, and are therefore both subject to ‘the powers that be’ (Fisher, 1986; Fisher & Groce, 1990). Many patients, for example, perceive their doctors as aloof and not willing to be bothered with unwanted questions and therefore refrain from asking them (Dreyer & Geist, 1993; Phillips, 1996). Patients are, in addition, in fact dependent on their doctors for matters as important as the relief of pain and avoidance of death (Atkinson, 1995; Mishler, 2004). Many patients in the Greenland emergency unit thus perceived their choices as to whether and how they might act as restricted, fearing that if they challenged their doctors they would receive inferior care:

“But you can’t say anything because you don’t know what kind of an attitude they might have.”

“And you can’t ask for anything because then they want to know why you want this and why you want that.”

One patient, in his conceptualisation of his situation, reveals the reality of the power the doctors possess:

“What can I say? I want help so I must accept.”

Thus, the negation of patients’ personhood and capacity for action is generally unchallenged by their uniform appearance and general silence and motionlessness.

Patients' resistance

It would not be true, however, to say that patients never resist their doctors' constructions, exercising agency within their interactions with them. It is, however, a relatively rare occurrence and one that involves overcoming resistance, rather than making use of a readily available channel for expression. The man who had overheard the doctors on the ward round groaning about his need for a 'PR', for example, subsequently asked Dr F, when she came to see him,

"What is a PR?"

"It's an examination from behind," she replied.

"Why didn't you explain before?" he demanded, not only requesting the information he desired but also asserting his right to an explanation and his disapproval of the doctor's prior omission.

Some patients even contradict their doctors' statements. A young man diagnosed with TB insisted on more rigorous measures than an X-ray to confirm his diagnosis before he would commence treatment:

"It might look like TB on the X-ray," he told his doctor, "but it doesn't feel like TB," both asserting his contrary belief and the importance of his subjective experience of the disease.

But on those occasions when a subject does emerge from this sea, asking questions, complaining about his treatment or ranting and raving insanely, there is little hesitation in the employment of more effort in suppressing the disruption. A woman hanging around the doctors' station waiting for information is told to "Sit!" A man asking too many questions to "Sit down!" And another to "Just sit down and wait!" And when such commands fall on deaf ears, the disruptive individual is frequently restrained by force or sedation or both.

Another consequence when patients do exercise agency, as described by authors including Millman (1977), Strong and Davis (1978), Fisher and Groce (1985) and Mizrahi (1986), amongst others, is their labelling as 'problem' or 'bad' patients. The

labelling of psychiatric patients in the Greenlands emergency unit is especially interesting in this regard, making explicit the relationship between the words doctors use to describe their patients and the demand for their passivity. In addition to “psych patients” and “crazies” – “How many crazies have you got here? D’you guys still have about ten crazies lying around?” –, these patients, who tend not to adhere to the unit’s norms, are termed, “walkers” and “helicopters.” The latter two labels are particularly revealing, not only disguising the patients’ personal identities, but also highlighting their defiance of the demand that they remain seated or bed bound. That a person should be singled out for doing something so ordinary as walking is not merely absurd, but attests to the strength of the expectation that patients should remain in their chairs. That those who do not are liable to be named as “helicopters” alludes to the anxiety that their walking about produces in their doctors. When I asked Dr W,

“Why do you call them helicopters?”

“Because they’re circling us!” he explained, his hands whirring in circular movements above his head.

More often, perhaps as a result of these negative sanctions and as discussed by authors including Fisher and Groce (1990), Cicourel (1999), Fainzang (2002) and Zaman (2004), patients resort to less forthright means of exercising agency, going little further than resisting their doctors, without actually proposing an alternative course, very often in ways that fail to serve their best interests (Fisher & Groce, 1990; Zaman, 2004). Dr A was interrogating a man brought into the hospital for a condition related to his drug abuse:

Dr A: So the last one you took was on Monday?

P: Yes.

Dr A: So you are going to stop it?

P: Yes.

Dr A: So you understand the risks?

P: Yes.

Dr A: [To the other doctors] OK, so lets do an ECG and I'll try to explain to the patient about, you know, the risks.

P: I'm not a psych patient.

[No reply from the doctors.]

P: The other doctor said I can go home.

Dr A: But you are going to go back to tik¹⁹, hey?

[No reply from the patient.]

Dr A: You take tik, hey?

[Patient nods]

Dr A: And dagga²⁰?

[Patient nods]

Dr A: So are you going to stop?

P: Yes (..) OK, so am I discharged now?

Dr A leaves little room for the patient to assume an active role in the conversation, requiring no more from him than monosyllabic answers to questions that are little more than statements of that to which she would like the patient to agree. At one point the man interrupts the flow to contradict what he suspects is the doctors' assumption – "I'm not a psych patient." But even this contrary and uninvited statement represents little more than resistance against what he imagines is the doctors' point of view, rather than initiating any viewpoint of his own. He then offers, "The other doctor said I can go home," clearly angling for his release but invoking the agency of another doctor no longer present, rather than owning the request for his freedom. To Dr A's question, "But you are going to go back to tik, hey?" he gives no response, failing to comply but only in the form of a refusal. His final question, "OK, so am I discharged now?" reads, in this context, as a last-ditch attempt to reclaim some of the agency he has forfeited in his previously complaisant responses. In answer to the doctor's accusations of drug abuse and to her request that he confirm his intention to stop he replies in the affirmative. But the question about his discharge with which he follows up his answers casts doubt on the truth of his

¹⁹ Street name for methamphetamine.

²⁰ Marijuana

prior statements and seems to point to his employment of the desired responses in order to achieve his own end, namely his release. In this roundabout way that illustrates the strange mix of resistance and compliance that Fainzang (2002) discusses in her analysis of patients' lies to their doctors, this patient attempts to exercise some degree of agency, and to reclaim some of that which he has forfeited, in a situation in which he remains, by and large, disempowered.

The power of sole subjects

When combined with the doctors' unquestionable position within the narrative of science, as discussed in the previous chapter, and the legal authority imputed as a result to the doctors, the diminishment of patients' agency leaves doctors in the position of unchallenged agents, redoubling their power. While Dr V begins in the following story by attempting to persuade a man of his point of view, and thereby to influence his actions, he resorts, when this tactic is unsuccessful, to stating his institutionally-given right to determine the patient's course (Fisher, 1986). The patient was a young man, accompanied by his father, who was adamant that he wanted to remove his son from the hospital and to send him instead to a traditional healer who, he felt, would be better able to address his complaint, namely confusion following a fit.

"I respect traditional healers," began Dr V, attempting to persuade the father to leave his son in his care, "but they can't fix this."

Failing to achieve agreement, Dr V continued: "Sir, I do not recommend that you take your son out of the hospital. There is something wrong in his brain that has caused the fit and we do not know what that is yet. But it could be TB or it could be cancer."

When the father still maintained his original position, Dr V resorted to employing his weight as an authority on the state's behalf:

"With all due respect, you do not have the right to take the patient out of the hospital. If a patient is confused we are not allowed to let him go."

Accepting defeat, the father left the hospital, requesting that he be kept informed of his son's condition.

Dr V's initial strategy is to use reason to attempt to change the father's mind – "Traditional healers...can't fix this." When this fails he employs his position as the keeper of scientific knowledge, or truth, to add weight to his approach – "There is something wrong in his brain that has caused the fit and we do not know what that is yet" – and then gives fear a try – "It could be TB or cancer." When even this fails he drops the mask from the position of absolute power that he holds, clearly articulating the man's incapacity to act according to his own judgements – "You do not have the right to take the patient out of the hospital," and, by implication, his obligation to accept the doctor's orders.

While this excerpt thus clearly illustrates the unequal distribution of power between doctors and patients, multiple meanings again peer out from beneath the surface. In the same breath that Dr V asserts his authority over the patient's freedom and future treatment, he denies responsibility for having wrested it from his father, invoking a greater authority than himself, within whose power "we," the medical collective "are not allowed to let him go." Again, this wording suggests a heightened sensitivity to the possibility for criticism of the doctors' actions and a consequent shirking of individual responsibility for the decision he has taken. While I draw attention to these emergent meanings at this point, they and related issues will be dealt with in greater depth in the following chapter.

Again, my descriptions of the inequality between doctors and patients and of the power that doctors can and do exercise over their patients in the unit cannot be left without reference to the excessively difficult position in which the doctors find themselves. Under no circumstances can they allow their patients free reign in the unit for fear of serious disruptions to the practice of emergency medicine. However, without entering into a debate about the necessity for the swiftness, severity or style of the suppressive measures employed, my argument is that the resulting passivity of the blue-clad figures contributes to their construction as subjectless entities, and that the consequences of this are damaging in multiple ways.

The narrative possibilities for subjects and objects

Within a context construed in the above terms, and inhabited by actors with the above characteristics and capacities, a range of actions on the part of both doctors and patients that might otherwise be deemed unacceptable become permissible and even likely, while other possibilities are obscured or prohibited. My argument in this thesis is therefore that construction of doctors and patients in opposite terms, as subjects and objects, respectively, can have serious consequences for the delivery of humane healthcare. I will discuss this possibility, addressed in the existing literature by only a few authors (for example Lorber, 1975; West, 1984; Mizrahi, 1986; and Andersen, 2004), with particular reference to the likelihood of communication and empathy within doctor-patient interactions, and to the attribution of responsibility when things go wrong.

Personhood and communication

As argued by Fisher and Groce (1990), the conversations that occur between doctors and patients can be seen as micro-political events, in terms of which processes of subordination and domination are played out through the medium of diagnosing and treating disease. And, as previously discussed, authors including Mishler (1984: p. 127) have argued that the dominance of the ‘voice of medicine’ “impairs and distorts essential requirements for mutual dialogue and humane interaction.” A significant number of authors, particularly those working within the mode of conversation analysis, have drawn attention to the multiple ways in which the structure of medical conversations enables doctors to control the form and content of interactions with their patients, including the patients’ contributions to these (Atkinson, 1981; Mishler, 1984; West, 1984; Fisher, 1986; Fisher & Groce, 1990; Heath, 1992; Sarangi & Roberts, 1999; Boyd & Heritage, 2006; Heritage & Robinson, 2006; West, 2006).

Between us, about them

Consistent with the work of these authors and confirming the validity of Fox’s (1989) observation that the distinction between doctors and patients as groups is not merely conceptual but is enacted by the individuals who are part of them, the Greenland emergency unit’s doctors identify with one another and exclude others through

conversational means. The vast majority of the doctors' exclusionary transactions go unmarked as such and simply take the form of conversations held between themselves, illustrating Goffman's (1961) analysis of the restricted flow of communication between groups in what he calls 'total institutions', of which the hospital is one. Many of these transactions are quite unobjectionable and can only be said to be exclusionary on the ground that they rarely, if ever, include a patient. But others are held about and in front of their patients, who are neither included through eye contact nor able to understand the scientific and terminology-filled content of the discussion. These discussions, more often than not, concern the patients directly in their reference to the doctors' plans for their treatment and care (Goffman, 1961) and illustrate what Goffman calls "the wonderful brand of 'nonperson treatments' found in the medical world" (as cited in Lorber, 1975: p. 213).

Examples abound. As subjectless entities, doctors frequently fail, as previously mentioned, to address their patients during ward rounds, referring to them only in the third person (Mizrahi, 1986) – "She's a 37-yr old woman with post-TB bronchiectasis," or, "You should have seen him when he came in this morning! (laughs)". When doctors do address their patients they do so almost exclusively to elicit information pertinent to diagnosis and treatment or to issue instructions, reverting to their exclusive communications as soon as the relevant end has been achieved. Dr A, for example, requests of her patient, "Can you just lie down?" following it immediately with a comment addressed to her colleagues on the round: "Ja, I think she'll have to come in. This one needs to be sorted out." While she addresses her patient to issue an instruction, Dr A directs the expression of her opinion regarding the patient's further treatment only to her colleagues – "I think *she'll* have to come in." Frequently, the patient is addressed only at the conclusion of the round's discussion of his case – "We are going to keep you here for a few days," or, "You can go home after you've been to the pharmacy to get your medication."

No reason exists for doctors to provide their patients with information about their diseases or possible treatments – devoid of subjectivity and with no capacity to act in

either an informed or uninformed way, the patients are spared the need for information and their doctors the obligation to supply it. A man who was unable to walk and who had been moved from the wheel chair he had initially occupied sat in an ordinary chair in the medical holding area, feeling, as he told me, “helpless” and “at the mercy of people who don’t care.” Having read the words, “high risk” in his referral letter and unable to make out the remainder of its contents, his anxiety was rising. With his experience invisible and indeed impossible, the doctors’ actions, as narrated by him, might be expected. During the hours he spent waiting, various doctors approached him, opened his folder and, offering no explanation or even greeting, walked away.

While in this example, the consequence to the patient was merely anxiety, the following example illustrates an instance in which it may have been much more serious. The case of a man who had been diagnosed with diabetes on arrival at the hospital, was discussed at his bedside:

Dr 1: You guys saw this gentleman here who’s a- (.) a newly diagnosed diabetic I believe. (..) Basically the plan was to check if he had a- check his ketones-

Dr 2: A newly diagnosed diabetic. What was the story? He came in with a high- high glucose.

Dr 1: I’ve got the results.

Dr 2: Oh. And?

Dr 3: But was not acidotic?

Dr 1: No.

Dr 3: What is a normal PH?

Dr 1: Its-

Dr 2: Seven point four. (..) Well there’s a range. Seven point three five to seven point four five.

Dr 3: (..) Ok.

Dr 1: He’s got ketones in his urine so I- I’d monitor-

Dr 3: Ja I mean he is not acidotic so it’s not a DKA²¹.

²¹ Diabetic keto-acidosis: a life-threatening condition caused by an insufficiency of insulin in the body, resulting in the breakdown of proteins in order to produce energy.

Dr 1: Mm.

Dr 3: So um- (..) But I mean the white cell count of eleven- (..) Where is that coming from? (..) The dipstick? What did it show?

Dr 1: Protein- what?

Dr 2: Ok. Blood trace. Protein trace. Ketones three plus. Glucose two plus.

Dr 3: And the chest X-ray?

Dr 2: Normal.

Dr 3: So I think (..) we can start him on (..) on uh- (..) [to patient:] How old are you?

P: Thirty three.

Dr 3: I think we can start- So- so young, hey? For a type two.

Dr 2: It is young for a type two. He's probably going to end up being a type one.

Dr 3: Ja. I think we can take our chances and- and start on orals. (..) But if he comes with a DKA next time then we can start type one treatment.

Dr 2: Ja.

[Doctors continue discussion of the appropriate drug and dosage.]

Dr 4: Is he discharged?

Dr 3: Ja he's going to go home. (..) You can start on type one treatment if he comes back.

[Doctors move on to the next bed.]

The above dialogue is typical of the conversation on the doctors' rounds and makes no attempt to include the patient beyond Dr 3's request for his age, providing a classic example of the ways in which patients' understanding of doctors' talk is obfuscated through the use of jargon, acronyms and so on (Wodak, 1996). While it remains unarguably necessary for doctors to efficiently convey information about their patients to one another, necessitating conversation of a scientific nature, their failure to communicate their conclusions to the patient highlight the exclusionary nature of this conversation. In addition, the doctors fail to include the patient in the making of a decision in which he is almost certain to be interested, unquestioningly assuming the dominant position as those most linguistically competent within the medical setting (Wodak, 1996), and thus disregarding the patient's right to inclusion in decisions that

affect him. From their position as sole subjects, the doctors decide to treat the man as a type two diabetic, although there remains some doubt as to the correctness of this assessment, arguing that they will change their strategy if and when the patient subsequently presents “with a DKA.” Whilst from their point of view this decision may seem the most pragmatic, there is a clear omission in procedure in that the man in question has not been consulted as to his willingness to take such a chance. The implications of the doctors’ decision are in fact of serious consequence and concern the patient directly: if the man is a type one diabetic, the oral treatment prescribed for type twos will not control his sugar level nor reduce his ketones, which will, presumably, continue to climb until he becomes acidotic. Their theory is that he will then return to the hospital “with a DKA,” at which point he will have proved himself to be a type one and be treated accordingly. Although the doctors may find it appropriate to “take (their) chances,” the risk to the man is great, even if the likelihood of their error is small – ketoacidosis is a life-threatening condition – and to take such a decision on another’s behalf, without so much as informing the person in question, would surely in any other context be considered unacceptable.

When cooperation is needed from their patients in order to fulfil the doctors’ tasks, instructions are issued without explanation – “Come.” And, when these instructions are not obeyed, the doctors deem it acceptable to follow them with threats:

“Work together with me please, d’you want to go home or d’you want to stay here?”

To a man who had suffered an epileptic fit at work that morning, was anxious that he might lose his job and was receiving instructions on the management of his newly diagnosed illness:

“No, they won’t fire you – if you’re epileptic and you take your medication you can do your job. Only if you don’t take your medication then they’ll tell you you must find another job where there’s no risk.”

The threat is obvious – “if you don’t take your medication then...” – disguised as a consequence beyond the doctors’ control – “*they* will tell you you must find another job.”

And a man suspected of a psychiatric complaint and who was hanging around the doctors' station asking questions about the likelihood of his release was told, "You better sit down cos you're behaving a little bit weird now. Just now somebody's going to think that you are crazy."

Speaking to objects

In addition, when the doctors do address their patients it is in a manner quite different from that commonly used to address an equal subject. For example, their employment of language and tone differs markedly from that reserved for each other, illustrating the use of a special tone of voice for communication between distinct groups in the total institutions that Goffman describes (1961). Dr P describes a colleague's surprise when, addressing his patient as an inferior 'other', the man responded as a competent equal, challenging the doctor's implicit assumptions:

"You know, you get into this mode of almost treating the patients like children and they- And you talk differently to them. You talk slowly and treat them like almost retarded people sometimes, it's sad. You know, but I remember, it was- actually happened to a friend of mine. And- and he was laughing about it and- Cos he said, 'Baba'²², tell me. What (.) pillies (.) have you been taking? So the- so he went, 'Erythromycin 500mg three times a day'. And the guy was like, 'Oh!' (laughs) 'I didn't even know that was the dose!' You know, so he was just like, his eyes were wide open, this guy knew, you know, plenty about it."

Dr P, in this extract, overtly admits and disapproves of the fact that doctors "talk differently to (patients)." Once again, however, something more simmers beneath the surface. His use of the pronoun "you" again appeals to me to include myself amongst those who might be guilty of such an action, seemingly requesting an empathetic response and generous evaluation and alerting me to the possibility of a latent self-doubt. He goes on to assure me that indeed it is not he who is the protagonist of his story. Further denying the truth of an imagined accusation, the word "actually" carries the connotation that I might be persuaded otherwise – *in spite of what you might think* it "happened to a friend of mine." The incongruity between his friend's manner of

²² Xhosa word for grandfather, respectful address of elderly man.

approaching the patient as if he were “almost retarded,” and the patient’s response – “Erythromycin 500mg three times a day” – proclaims the inappropriateness of the doctor’s habitual manner and the inaccuracy of his implied judgement of the patient as inferior. However, as much as he asserts it, Dr P simultaneously attempts to diminish the crime, preceding his evaluation of his friend’s manner with a mitigating “almost” – he approached the patient “as if he were *almost retarded*.” He applies the same strategy in describing the tone in which the doctors “*almost* treat... the patients like children.” Once again, the multiple and contradictory meanings of the doctors’ talk, in which claims are made and denied in the same breath, alert one to their inner ambivalence, an ambivalence that I will argue in the following chapter is comprised in the conflict between power and vulnerability, certainty and doubt, and irreproachable and guilty self-evaluations.

The mutuality of one-sided conversations

As discussed with reference to the construction of patients as passive, these exclusive conversations cannot be construed as entirely one-sided. Very seldom do patients challenge their own exclusion, for example with interruptions or questions. An incident in which the doctors on the ward round attempted unsuccessfully to identify a patient provides an extreme but illustrative example. The patient was sitting slumped on the floor in the corner of the unit, all chairs and beds being occupied.

“The other one in the corner here?” enquired Dr G.

“I don’t recognise him,” claimed Dr M, bending down to look more closely at the man, who simply gazed back at him. Looking up at his colleagues, “D’you recognise this guy?” he asked. “Maybe it’s one of [Dr R’s] patients.”

While none of the doctors present thought to ask the man himself for information as to his identity and that of the doctor who had originally seen him, no more did the patient venture any contribution toward answering their questions, behaving instead as the passive object of their discussion. Without resolving the matter, the round moved on and the patient remained unattended to.

As with the exercise of other forms of agency, on those occasions, however, when patients do challenge their exclusion they tend to be met with more decisively

exclusionary tactics. An elderly man had arrived at the hospital with pains in his chest. He was accompanied by his son and had been examined by Dr F, who now stood at his bedside, discussing his case with a student. Both father and son were obviously interested in the doctors' conversation, openly attempting to hear and to follow its course. They leaned anxiously forward, intent but uncomprehending, until, apparently having gained little in the way of enlightenment, the patient's son spoke up:

"What are you saying?" he asked Dr F.

"No, I'm just talking to him," she replied, gesticulating toward the student and continuing her 'private' conversation.

Not only does Dr F's response fail to provide the patient with relevant information, it reconstitutes his son's question as one based on misunderstanding rather than on any appropriate desire for knowledge. Correcting the 'error', namely that information might be passed from doctor to patient as well as between doctors, with a clearer assertion of the intended direction of her communication, Dr F defends the borders of the conversational arena, reminding the patient of the unacceptability of such an exchange as he had attempted.

Personhood and empathy

The opposite constructions of doctors and patients further inhibit the doctors' ability to identify or empathise with their patients, their construction as 'not us' denying all possibility of similar or shared experience, as discussed by authors including Mizrahi (1986), Andersen (2004) and Maynard (2006), and evidenced by the fact that doctors' talk rarely includes any reference to their patients' perspectives, or suggestions that they can imagine being in their patients' shoes. While Goffman (1961), Mishler et al. (1981) and Lorber (1975), amongst others, have pointed out the value of emotional distance between doctors and patients, enabling them to perform and endure invasive or distressing procedures and enhancing efficiency, these and other authors, such as Mizrahi (1986) and Helman (2001) have emphasised the simultaneous negative, if unintended, consequences that are the too frequent result.

As objectified persons, the practices discussed above, in terms of which doctors discuss their patients in their presence, for example, without any attempt at including them in their discussions become acceptable. Most striking, in the context of the Greenland emergency unit and the present argument, are those occasions on which the doctors' conversations concern matters of a highly sensitive nature, exposing their lack of consideration for their patients' subjective experiences through the insensitivity of their discussions, and paralleling the undignified and humiliating treatment of patients described by Turnbull, Flabouris and Iedema (2005), and the 'cold' and 'heartless' treatment of patients that Maynard (2006) describes. Standing before a man to whom he referred as "a ratex OD," Dr G asked his students,

"What's ratex?"

When no response was forthcoming he proceeded to explain: "It's rat poison, OK. But the one this guy took, its not the household one. The household one's Mickey Mouse stuff. The industrial one is the proper one."

It seems reasonable to assume that, for the patient, who had attempted suicide the previous day, this statement could have been more sensitively phrased. Of a man awaiting a "PR,"²³ Dr M groaned, "Why does everyone have to have flippin' bleeding?" expressing his aversion to the required examination. The patient told me in our subsequent conversation that, while he did not know what a "PR" was, the doctors' discussion around the issue had made him anxious and indeed angry at their failure to include or respect him.

These conversations even, on occasion, include jokes between the doctors at the patients' expense. On one such occasion, the doctors were gathered at the foot of a young woman's bed. Dr A, leading the ward round, addressed her colleagues:

"OK, she's a known epileptic, she has taken some of the pills. She thought she was going to have a fit and she took 10 pills."

"Ten!" repeated Dr M, as snorts of laughter resounded through the group.

²³ Per rectum – refers to a rectal examination. Earlier ref footnote there

The patient, who had not been addressed, was looking depressed and ashamed, sitting up in her bed with her face turned away, avoiding the doctors' gaze. As the ward round moved on she pulled the blanket over her head. Such insensitivity, I believe, is made possible through the 'othering' of patients, who cannot be expected to feel as the doctors might.

Failure to recognise their patients' subjectivities also frequently results in doctors' physical treatment of their patients as objects. A doctor, for example, taped a piece of paper reading, "Admit Ward 1," to a woman's shirt, like a sign one might post on an inanimate object but that struck me as inappropriate for a person. I observed also, on a number of occasions, that doctors stuck name tags to their patients' foreheads, similarly dispensing with the usual treatment of a human being. In one instance Dr G, without greeting the patient in question, lifted a man's arm, showing it to his colleagues. "D'you see this?" he asked, proceeding to point out and explain the signs of disease. Later, again without greeting the patient, the same doctor took hold of the head of a man seated on a crowded bench. Moving it backwards and forwards and round and about, he pointed to various features of the man's neck, all the while talking to his colleagues and students and never uttering a word to the object of discussion, namely the sick man.

My argument is that, through their constructions of their patients as devoid of subjectivity, the doctors obviate the need for their treatment as different from objects, rendering ordinary communication and empathy not only superfluous but indeed unthinkable. Dr W's cynically humorous comment, "When I grow up I want to be a mechanic," attests to the accuracy of these interpretations, pointing at the same time, however, to a self-conscious awareness of the fact that their patients are in fact fundamentally different from motor vehicles and thus both to the unacceptable nature of the way they are often treated and to the frequent replacement of 'detached concern' with 'overdetachment', to which doctors operating under stressful conditions are susceptible (Mizrahi, 1986).

Collective identity and responsibility

The distinct identities constructed for doctors and patients, and in particular the collective nature of these, in terms of which individuals are ascribed to groups and defined in terms of their membership of them, further facilitates the sharing of responsibility, which is often ascribed to the group rather than to the relevant individuals: “We could see he wasn’t gonna do well,” “We thought he’d be fine,” “We discharged him this morning.” The doctors in these descriptions see with one vision, think with one mind and act as a unit, no single doctor identifiable as responsible for any particular action.

Frequently, doctors share responsibility in the form of joint decision-making, an unarguably desirable practice that holds much promise for protecting patients’ interests by reducing the likelihood of mistakes or oversights. Dr G provides an example already discussed in which he takes a decision of considerable weight and requests the support of his colleagues:

“If she doesn’t have miliary TB its untreatable at the age of 80. I think, basically, she goes to (external ward). TB treatment. If she doesn’t get better, nothing else. Do you agree?”

Here, it seems absolutely right and proper that this decision should not be taken by one man alone and the doctor’s inclusion of others seems responsible. However, there are other instances in which the attribution of responsibility to the group rather than to an individual serves to defer responsibility from the self, rather than to include others in it. This process, as discussed by Mizrahi (1986), allows actions to be conducted, or decisions taken, by ‘us’, rather than merely by ‘me’, offering protection from personal accusation and thus the potential for errors or worse to be committed without risk of personal blame. Again, this relationship between the form that doctors’ and patients’ identities assume and the avoidance of responsibility suggests a possible link between the doctors’ eager assumption of powerful positions and a lurking self-doubt, and thus to the relationship identified by Rosenthal (1999) between collegiality and uncertainty. Dr N, self-consciously aware of the frequently poor communication between doctors and their

patients in the unit, talks about the difficulties he and, by implication, the other doctors, encounter in attempting to communicate with their patients:

“Like, you want to give them the information, cos you’ve learned to- to give them information, explain things to them, ask them if they understand, clarify any questions that they may have. So you learn that style ... and you wanna give it to your patients, ‘Do you have any questions?’ ‘No, doctor’. (laughs) ‘D’you understand everything?’ ‘Yes, doctor’. (.) And they’ll walk out of there (.) and still not be clear as to what’s going on. And will not be able to communicate that to the next- to the family member um (.) because it was like- it’s, you know, you don’t ask questions of the doctor. You know, it’s that, ‘don’t question the doctor’.”

While in all my conversations with the doctors I expressed an explicit interest in their personal experiences in the emergency unit, they responded, in the main, in general terms, concealing themselves within a group of individually unidentifiable doctors. Their interesting use of the pronoun ‘you’, as evident in the above extract, that seems to contain an expression of the unity and mutual identification between all doctors, appeared further to appeal to me to position myself as one of them in listening to their stories, alluding again to their perceived need for a sympathetic interpretation of their actions. In this extract Dr N, through his use of the pronoun ‘you’, identifies himself, and admits his own responsibility for the ultimately unsuccessful communication of which he is speaking, only as one amongst the “the (many) doctor(s)” whom the patients “don’t question,” and begs that I, the listener, identify myself also as one of those who would be unsuccessful, given similar circumstances, through his implication that it is not only us but “you” too who (would) fail.

Trying ever harder to encourage the doctor to speak of actual events in his personal experience, I persisted:

“I don’t know if you can remember any particular patient where you felt that that was what was going on?”

This elicited the following reply:

“(...) Um (...) Ja, there isn’t- I’m struggling to sort of pinpoint. There’s a lot of- I got a lot of- I got a lot of scenarios but I- I wouldn’t say ac- you know, there’s this- I can’t think- Af- after a while, when you see so many patients a day, you don’t ac- you actually don’t remember the particular patients, except what you re- you remember scenarios like (...) you know, there- you know, for example say a scenario that I often use as an example is like, you know, a patient who’s given a diagnosis of cancer. (...) You know, you tell them it’s likely that this is cancer, we don’t have absolute proof but the ultrasound suggests it, etc, etc, etc. You give them the- (...) but its, ‘Yes, doctor, ok that’s fine, doctor’ and then that’s it. Off they go and (...) you know, its- (...) you don’t know how much has sunk in, or, you know-”

Stumbling at first, the doctor fumbles for firmer ground – “Um (...) Ja, there isn’t- ... There’s a lot of- I got a lot of- ... I- I wouldn’t say ac- you know, there’s this- I can’t think-” – finding his feet again only once he is safely back on more generalised terrain – “You know, for example say a scenario that I often use ... is like, you know, a patient who’s given a diagnosis of cancer.” Having faltered in his response to my request for a more personal story, Dr N’s repetitive “you knows” seem to crave my agreement and assert that of the rest of the world, echoing with the implication that what he is saying is something that we all know, and thus denying personal causal responsibility – the fact that doctors regularly fail to achieve mutual understanding with their patients is a phenomenon that exists in spite of him or anything he might do. Similarly, his construction of the event in which a patient *is given* a diagnosis of cancer disguises the active subject and represents an instance of the passive linguistic constructions to which Katz (1984) refers in his discussion of medical avoidance of responsibility. Tellingly, Dr N switches suddenly to use of the active “I” when describing more successful ventures, illustrating Maynard’s (2003) argument about the differential attribution of responsibility for good and bad events:

“I always- I have learnt to say, (...) ‘When you come back for your results I want you to bring a relative with you’. (...) I’ve learnt to do that ... And then I often counsel, in terms of a final diagnosis with both of them there.”

In addition to evading their own individual responsibility for adverse events, doctors also make use of their shared identity, as part of the repertoire of devices available within medical culture for dealing with inevitable mistakes (Mizrahi, 1986), to protect one another from the same burden. Dr R's response to Dr F's story, referred to earlier in the chapter, of the baby who had died before being seen by a doctor is a case in point:

Dr R: "Mm, I wanted to ask – what actually happened? Did the mom come in and dump the baby or what?"

Dr F: [The mother and baby had been kept in the triage area, where nurses take patients' blood pressure, pulse and blood gases before assigning them a coloured sticker that indicates the urgency with which they need to be attended. No doctor had been alerted.]
"No one told us there was a baby (..) we were shocked."

Dr R: "But that triage system is also wrong. Even if the baby looked fine someone should have come and said there's a baby. I mean we all know how quickly those guys crash."

In her opening question, Dr R presents Dr F with an external target for blame before even hearing her story – "Did the mom come in and dump the baby or what?" – presuming the doctor's innocence and offering to displace responsibility for the baby's death onto either the mother or, subsequently, "that triage system (which) is also wrong." Thus, Dr R can be seen to enact the norm of non-criticism of which Mizrahi (1986) writes, pre-emptively discouraging any admission of culpability or guilt in Dr F's anticipated telling of the story, and thus protecting not only those doctors present at the time of the baby's death but also herself and indeed the whole profession from possible similar accusations, both past and future (Millman, 1977). Dr F, in her reply – "No one told us there was a baby (..) we were shocked" - responds in kind. She overtly denies responsibility for the baby's death, directing it instead to all those who did not tell "us," and thus displaying use of the most discussed of the tools in medical culture's repertoire of defenses, namely blame (Mishler et al., 1981; Mizrahi, 1984; 1986; Paget, 1988; Zagier-Roberts, 1994; and Wodak, 2006b), in this case presumably of the patient's mother and of the nurses. Dr F further seeks cover from potential accusations of personal culpability even before they are made – it is "us" rather than "me" on whose behalf she denies responsibility, as she disappears, so to speak, into the crowd before she can be singled out and accused.

Interestingly, this was not the only account of events circulating the room. The senior consultant, whose responsibility it was to determine the truth, and who had acquired the nurses' side of the story too, claimed that the nurse who had performed the baby's observations, finding "virtually no blood pressure," had immediately reported the situation to a doctor. The mother and baby were nevertheless left waiting in the triage²⁴ area from 9 p.m. until 3 a.m. the following morning, during which interval the panicking mother had entered the casualty on at least two occasions, only to be told by a doctor to "Sit down and wait!" On the last occasion she had entered the casualty, it was too late – "the baby was already gasping." At the end of the day, the head of department had reached a conclusion that protected everyone from further investigation: "It wasn't negligence. I think it was just stupidity." This extract thus highlights the validity of Paget's (1988) concern, namely that the professional etiquette forbidding criticism both unites doctors against the lay community and simultaneously allows individual doctors maximum autonomy, creating the potential for the development of what he terms a 'delinquent community' within which poor practice remains unaddressed and the collective beliefs that enabled its occurrence are perpetuated and reinforced (Alsop & Mulcahy, 1999).

The counter discourse

Again, however, a counter discourse does exist, albeit only in the occasional actions of a few doctors. On these occasions doctors can be seen acknowledging their patients as subjects, including them in conversation, recognising their lifeworlds and subjective experiences and even identifying and empathising with them. The following incidents illustrate the possibility for the enactment of this counter discourse to positively impact on the quality of care delivered in the unit in terms of its humanity and even, potentially, its effectiveness.

Dr M, for example, frequently referred to his patients by name or spoke of them as "this guy" or "this lady." These more particularising references go further toward

²⁴ Screening area in which basic observations are performed, in order to assign patients a colour indicating the urgency with which the case needs attention.

acknowledging the patients' personhood and even similarity to doctors than does the 'one-size-fits-all-except-us' label of 'patients'. In fact, on the first occasion that I met this doctor, my attention was drawn to him when I observed him introducing himself to a patient and shaking the man's hand – ordinary practice outside of the hospital but quite remarkable within it. Dr Z, too, on a number of occasions included his patients in conversations and even in jokes made on the doctors' rounds. A diabetic patient had arrived in the unit with a very high sugar level after failing to take his medication for a full seven months. It emerged, during the conversation held between Dr Z and the man, that he had believed himself cured. As usual, the doctors on the round laughed at the patient's misunderstanding and consequent mistake. Dr Z, however, included the man in the joke:

"You see," he explained, "diabetes never goes away. It stays with you forever like a loyal wife. (.) There's three things that never leave you – a loyal wife, a drunken husband and diabetes."

The patient and a number of others sitting around him laughed uproariously, along with the doctors.

What differentiates this joke from the multitude of others made at the patients' expense, and in which they are unable to participate, is, firstly, the fact that it was addressed to the patient himself. Secondly, the joke makes use of imagery with which the patient can identify. Rather than medical or aggressive imagery, which the patient would have been unlikely to find funny, this joke employs scenes from a more universal reality, namely the possible negative consequences of marriage, to illustrate a medical point. In so doing, it further acknowledges the patient's experience of illness, alluding to his hope that it would pass and to the frustration and disappointment associated with the realisation that it will not. Like a reprehensible spouse – or, for that matter, a virtuous one – the disease, he tells the patient, is here to stay. The joke thus bridges the gap between the layman's and doctors' understandings of disease, translating a medical rendition of the man's illness into non-medical terms and thus integrating Mishler's (1984) binary worlds of medical and subjective experience.

Interestingly, but unsurprisingly, this and similar instances in emergency room talk are frequently the precursors to conversational contributions from the patients themselves, who tend in other instances to be decidedly reticent. Dr Z had begun explaining the do's and don'ts of diabetes when the patient interrupted, "I don't understand," seemingly accepting the offer of conversational participation. Not only do such contributions from the patients enable their participation in conversation, they facilitate, as this extract illustrates, their ability to understand and assume responsibility for their illnesses. Other similar instances illustrate the importance of patients' participation in diagnosis. A woman's interruption when Dr Z told his colleagues that her heart disease resulted from a fatty diet, including her consumption of butter – "I don't eat butter!" – has the potential to alert the doctors to aetiological factors of which they may have been unaware, and thus possibly contribute to a more appropriate treatment and management plan.

A story that similarly illustrates the importance of the patient's lifeworld to effective treatment and management of disease involves a man who had, in addition to a variety of other symptoms, an infection of his toes:

"This is a very common complaint amongst people who live in shacks," remarked Dr Z. "It results from the constantly wet floors and the mud and the wet blankets."

Responding to the suggestion that the man should be discharged, he commented on its failure to account for the context of disease:

"But this man's problems come from living in a shack," he said. "It is therefore illogical to send him directly back to that shack."

On recommending that the man soak his feet daily in potassium permanganate, he pondered the feasibility of such a plan, including the patient in its formulation:

"How are you going to do it? (..) Do you live near a day hospital?"

And, of a man who presented with back pain, he asked,

"Was he given an X-ray?"

Dr T shook her head.

“The least you can do is an X-ray,” Dr Z replied. “Even if it shows nothing. This man is a labourer. He works very hard. And that work depends on his ability to sell his labour. So even if an X-ray doesn’t show up a problem, at least he will be able to see he is ok.”

The recommended investigation thus takes account not only of the man’s purely physiological symptoms but of how his condition fits into his lifeworld, thus broadening the possibilities for his treatment.

In yet a further incident, the same doctor displayed an awareness of his patients’ experiences of being in the hospital, an awareness that precipitated a compassionate act. An elderly woman who had suffered a heart attack was lying in a bed next to a young man in a most fearsome condition. He was shaking and shuddering frightfully and calling out incoherently in a terrible voice. Looking at the woman, Dr Z remarked to the others present, “She must be terrified,” and proceeded to advise them on the more sensitive treatment of their patients:

“You must always consider the other patients,” he said. “You should never put a drunk man next to an old lady. Get a porter to move him.”

I also not infrequently observed Dr A identifying and empathising even overtly with some of her patients. Concerning the plight of the dead baby’s mother, for example, she stated that, “I would be frantic. (.) I would definitely litigate,” clearly placing herself in the woman’s shoes and standing with the patient against the doctors as she commented regretfully, that “whoever was responsible would get away with it.” And in response to her colleagues’ mocking laughter at the woman who had stabbed her husband, she told them, “Don’t blame the patient for stabbing her husband. Maybe there’s a reason,” pointing overtly to the subjective experience that might have provoked such an action and alluding to the potentially understandable nature of such drastic behaviour.

In this, as in many of these instances, the doctors’ references to their patients’ subjective experiences serve to highlight the wrongfulness of the doctors’ insensitive acts, thus reinforcing the argument that the converse objectification of patients in the doctors’ talk enables and justifies their inhumane treatment. These alternative constructions, in which

doctors acknowledge the subjectivities and experiences of their patients, further open the way for medical practice that incorporates the subject and his experience in decision-making, generating the possibility for more individually attuned, and therefore realistically accomplishable, treatment plans. Such displays on the part of the doctors thus illustrate at least a tendency in the direction suggested by Mishler (1984) in his prioritisation of the patient's lifeworld as the basis for action, including treatment action. Not only do they indicate this tendency themselves, but the doctors' statements and questions that refer to their patients' lifeworlds also mark the beginnings of potential pathways to the delivery of more humane care.

Summary

In this chapter I have provided an analysis of the positions that doctors and patients occupy in emergency room discourse at Greenlands Hospital, using this as a framework for tying together disparate themes in the existing literature, including discussions of collegiality (Mizrahi, 1986; Fox, 1989; Good & DelVecchio-Good, 1993; Wodak, 1996; Rosenthal, 1999); accountability (Millman, 1977; Mizrahi, 1986; Paget, 1988; Fox, 1989; Rosenthal, 1999) the binary construction of doctors and patients (Goffman, 1961; Katz, 1984; Fisher, 1986; Mizrahi, 1986; Fox, 1989; Dreyer & Geist, 1993; Zagier-Roberts, 1994; Wodak, 1996; DelVecchio-Good & Good, 2000; Rothman, 2003; Maynard, 2003; Andersen, 2004); objectification (Mishler et al., 1981; Mishler, 1984; Mizrahi, 1986; Dreyer & Geist, 1993; Atkinson, 1995; Hak, 1999; Helman, 2001; Mishler, 2005; Potter & McKinlay, 2005) and labelling of patients (Millman, 1977; Fisher & Groce, 1985; Mizrahi, 1986; Atkinson, 1995); doctors' conversational exclusion of patients (Mizrahi, 1986; Dreyer & Geist, 1993; Atkinson, 1995; Wodak, 1996; Mishler, 1984, 2005; Helman, 2001; Potter & McKinlay, 2005); and patients' resistance and suppression (Katz, 1984; Fisher, 1984, 1986, 1991; Heath, 1992; Atkinson, 1995; Annandale & Hunt, 1998; Fainzang, 2002; Perakyla, 2002; 2006; Maynard, 2003, 2006; Mishler, 2004; Zaman, 2004; Tanassi, 2004; Wodak, 2006a), that can be argued to have implications for the delivery of inhumane care. Looking at the animation of these themes in the Greenlands emergency unit, I have shown how they are employed by the doctors in the dialogical construction of theirs and their patients' identities and of the inequality prevalent in the

unit. The analysis shows how doctors and patients are construed as binary opposites, establishing coherent, and indeed antagonistic, groups of 'us' and 'them'. Not only do these identities divide doctors and their patients but they offer doctors the position of acting subject and patients that of passive object, exacerbating already existent power imbalances. I have argued in this chapter that the possibilities produced through the narrative structuring of events, identities and experiences in the unit in terms of the themes identified by past research, as above, promote poor communication between doctors and patients, lack of empathy with patients on the part of the doctors and opportunities for individual doctors to avoid personal responsibility for adverse events. I have further identified instances of alternative discourses that emerge in the unit, alluding to the multiple layers of meaning present in the doctors' talk, including the doubt and ambivalence that are the primary subject of the following chapter, and highlighting the possibility for change.

CHAPTER NINE

AGENCY, RESPONSIBILITY AND SELF-DOUBT IN THE DOCTORS' NARRATIVES OF POWER

The manufacture of distinct groups of doctors and patients, as described in the previous chapter, not only produces a medical corps of all-powerful superheroes and an associated patient body comprised of passive blue objects. It also facilitates the projection of blame for adverse events away from the (powerful) doctors onto their (powerless) patients, leading to a paradoxical reversal of roles. In this chapter I will reveal this unexpected shift, only hinted at in the previous two chapters, in the positions occupied by doctors and patients within emergency room discourse and in the agency attributed to them. I will explain how this shift both complicates and reinforces the positions occupied by doctors and patients within medical culture. I will further show how doctors' positions within this discursive framework render them simultaneously powerful and guilty and how they endeavour in their stories of adverse events to prove their own innocence, blaming their patients for unfortunate occurrences, including the mismanagement of chronic illness, ineffective communication between doctors and patients, the patients' deterioration and death, and even for the doctors' own actions. I will argue that this blame necessitates the sudden attribution of agency to patients in doctors' stories of these events, inverting the order defined by the narratives of science and of masculinity and rendering doctors the helpless bystanders and even victims of their patients' actions. This inversion of the doctors' position renders patients, in turn, formidable agents, dangerous both to themselves and to their doctors. I will argue in this chapter that this 'narrative twist', through blaming the patient, enables the provision of inhumane care. Via the threat that it poses to doctors' positions as sole agents, it simultaneously represents an incentive to doctors to reassert their power and thus the breeding grounds for acts of abuse, further blame and so on, in a vicious cycle. The twist thus ultimately reinforces the very constructions within the narratives that it complicates, namely those of doctors as gods of science and heroes of masculinity, perpetuating the doctors' need to reaffirm their power and their patients' powerlessness.

Agency and responsibility

By way of introduction to the argument presented in this chapter, I would like to draw attention to the relationship first pointed out by Freidson (1970) and later by authors including Obholzer (1994) and Speck (1994) between agency and responsibility in medical culture, in terms of which all-powerful doctors are understood literally to hold their patients' lives in their hands, and therefore to be wholly responsible for the outcomes of care. As I will show in this chapter, the position that the Greenland doctors occupy as all-powerful agents in the unit, alone responsible for finding, "dragging," diagnosing and treating their patients, "let(ting)" them into and out of the hospital, and even raising them from the dead, becomes suddenly precarious in the face of negative outcomes to what must, according to their own definition, have been the doctors' actions. In their own terms and in those set out within the narratives of science and of masculinity, then, poor health outcomes become indicative of personal failure (Mizrahi, 1986) – indeed, as Zagier-Roberts (1994) points out, failure of the doctor's self as the instrument of care, setting doctors up to grapple endlessly with issues of culpability and responsibility (1984).

Dr S speaks of the massive burden of responsibility that she feels:

"Every patient there, any resuscitation that happens is my responsibility, every (.) person who dies who shouldn't cos they haven't been seen ... it is my problem and (.) it does all reflect and (.) you know, land on my conscience."

Dr N speaks of patients for whom there is little that can be done, nevertheless depicting their doctors as responsible for their deaths:

"I think- I think that's a lot- that a lot of it's well- the people who come here are so sick that there's (.), you know, (.) if they were motor vehicles they'd be (.) written off and scrapped. (...) Um (.) and (.) and you see someone and you think, what's the point? (...) And (.) then (.) from thinking what's the point (.) sometimes it becomes (.) an action of what's the point. (.) So (.) so (.) that patient will (.) get put into a corner (.) and (.) just allowed to die or- or- you know."

Dr P illustrates the exacerbation of the situation in a resource-poor setting, describing the magnitude of the decisions in which he and the other doctors frequently find themselves literally “playing God”:

“You know, you often making decisions which I don’t necessarily think you should be making but (.) you know, (.) whether or not you resuscitate a patient based on (.) if they’ve had TB or what their baseline is etc, etc, etc ... (..) Just- just purely because of lack of facilities. (.) So you know that the prognosis is going to be poor for someone who’s got bad lungs from TB (.) therefore if they come in (..) sick (.) then you don’t ventilate them because (.) they’re probably going to do badly and you’d rather keep the bed for someone with a good prognosis.”

All three doctors describe their patients’ deaths as the outcomes of their actions. Dr S, in the first extract, depicts her patients’ deaths as somehow traceable to her own failings, both performance-related and moral – “it does all reflect and (.) you know, land on my conscience.” Dr N implies through his statement that “sometimes it becomes (.) an action of what’s the point,” that in certain instances the doctors become, rather than the superheroes they are intended to be, the agents of death, “just *allow(ing)* (their patients) to die.” And Dr P describes instances in which his decision, for example whether or not to ventilate a patient in view of insufficient resources and patient overload, is the direct precursor to the patient’s death.

Responsibility, reality and the possibility for positive self-evaluation

The combination of these constructions of doctors as all-powerful superheroes on the one hand and of their responsibility for their patients’ deaths on the other places doctors in a position of extreme psychological difficulty. Dr R reminds us of the need created by the narratives of science and of masculinity for doctors’ actions to produce clearly identifiable results of a particular nature, as discussed with reference to their characterisation as ‘action men’:

“The weekend before that we had a trauma- we had a- we had a big trauma the weekend before that with head injuries and whatever. Came in in a very bad way. And we were actually able to sort of (.) not get him right but (.) get him in a stable enough position that we could send him somewhere that could get him right. (..) And those are the moments when you feel like (.) you’re doing something. (..) There’s- there’s- (laughs) there’s need for you to be here. (..) You know, it’s just- it’s very- it’s difficult now with HIV. Because (.) you get the feeling that like why do we even bother? (.) You know, these patients come in in stage 4, this woman (.) that I saw now (.) stage four, they’ve got PCP²⁵ pneumonia and they’ve had like reactions to all the medication they on and (.) you know, there’s really nothing you can do at that stage. It’s just (.) sit and wait and make them comfortable. And (.) 70% of the patients we’re seeing are like that. (.) Hh you know you kind of feel like why did I become a doctor if I’m gonna sit here and say, ‘Well you a right off, you a right off, you a right off?’ You know, it’s kind of- you know, it sounds harsh but that’s what’s happening. You know, you not gonna say to a patient ‘Well, you a right off,’ you gonna say, ‘Well, let’s look for some palliative care or-’ and you don’t ever feel like you’re doing something.”

Dr R makes evident the necessity of a particular kind of result, namely clearly identifiable diversion of the course of disease, for a doctor’s action to be considered worthy of the term – “those are the moments when you feel like (.) you’re doing something.” Actions unlikely to produce these effects, for example those involved in “palliative care,” produce, instead of the positive self-evaluations associated, for example, with successful resuscitations, questions about the value of the effort spent. Unlike other actions, identifiable as the causes of immediate effects, these actions are constructed, essentially, as non-actions – “there’s really nothing you can do at that stage” – equated to “sit(ting) and wait(ing).” That the value of the doctors’ identity is bound up with their potency as defined in these terms is hinted at by Dr R’s question in response to the many patients she sees suffering from full-blown AIDS – “Why did I become a doctor”? It seems, therefore, that the doctors’ characterisation as action-men, as the all-powerful causes of their patients’ emergence from disease and death, places their very

²⁵ Pneumocystis pneumonia

identities under threat every time they are faced with a reality that defies their ability to live up to this expectation.

These constructions place a millstone of unrealistic expectations and responsibility on the doctors and, I believe, account for the self-doubt that permeates so much of their talk, discussed in the two preceding chapters. In the remaining sections of this chapter I will articulate the process whereby these constructions of incurable disease and death in terms of the doctors' personal failure lead to self-doubt and the potential for guilt, blame and defensive reassertions of threatened power.

Guilty or not guilty?

As illustrated by Dr R's statement above, the nature of the work and the less than desirable conditions under which both the hospital and the community it serves operate and live, means that talk in the emergency unit abounds with stories of unhappy occurrences. These stories represent the 'narrative spaces' within which the cycle of power, guilt, blame and reassertions of power unfolds, and in which doctors attempt to secure their uncertain innocence. As in Maynard's (2003) discussion of doctors' use of passive grammatical constructions in their delivery of bad diagnostic or prognostic news, the Greenland doctors in almost all these stories suddenly deviate from their usual attributions of power and position, relinquishing their agency, as Katz (1984) has described, and projecting causal responsibility for adverse events away from themselves. Dr P tells me about a woman who had been misdiagnosed and left to die until the error was detected by chance and remedied, her subsequent death being allegedly unrelated to the point of the story:

Dr P: Um (...) There was one (.) time (.) where a- a lady came in – she was known with obstructive airways disease (..) and (.) um (..) and (.) no, it was a busy day (.) and she was very breathless (.) and (.) it was a quick examination and then she was- (.) you know, she was doing very badly and the decision was ag no, she's not gonna do well. (.) And then-
I: Sorry, what does 'not going to do well' mean?

Dr P: It means she's gonna die. (Laughs) So (.) um (..) so she was (.) put on a bed somewhere (.) and she landed up going for x-ray (.) for whatever reason, I can't remember why. And then (.) for some reason someone looked at the x-ray – she hadn't been reviewed cos it was decided nah, she's gonna do badly – and she had a large pneumothorax (..) which (.) is treatable. And that's most of the reason why she was doing badly. But it was no, she's got this disease (inaudible), it's just progression, she's going to do badly. (.) And (.) actually she did end up dying anyway ... Which (.) is (.) which is not- not justification, but-

Setting the scene for his story with a backdrop of mitigating circumstances – “it was a busy day” – the doctor makes use of some interesting sentence constructions that obscure those responsible for the misdiagnosis from view – “it was a quick examination ... and the decision was ag no” – the actions seemingly independent of any agent. Far from “drag(ing) (the patient) along,” as the doctors tend to do in stories with happier endings, this patient “*was put* on a bed somewhere,” a passive construction that fails to indicate an actor. In contrast to so many of their other stories, the patient is the only person present in this one, the doctors having disappeared, so to speak, into the woodwork. Glimpsed only for a moment when “someone” performs the less dubious action of “look(ing) at the x-ray,” they disappear just as quickly as soon as the trail of erroneous acts is resumed – “she *hadn't been* reviewed cos *it was decided* nah, she's gonna do badly.” Having erased the agents of error from the story, Dr P further denies that its outcome was related to their actions – “actually she did end up dying anyway.” Of course, he goes on to assure me, this latter “is not- not justification, but-” both offering it as such and denying that he is doing so in the same breath.

Dr S tells a similar story. Pursuing her assertion that she feels responsible for “every patient there ... every (.) hh person who dies who shouldn't cos they haven't been seen,” I asked her,

“So can you think of any time when something happened that you were responsible for?”

“I mean, it’s not necessarily responsible for-” she replied, shifting hastily out of her original position in response to what began to feel like my attempts to pin her down. She continued:

“It’s like (.) the person who had airway obstruction who waited eight hours, previous shift, and then who obstructed and (.) died even though I, I couldn’t- ja, I got a trachi²⁶ in but not quick enough. It’s that. That shit. That- (.) that’s because they’ve waited. And they haven’t waited cos the team in front of us have been sitting (.) on their arses doing nothing, because they’ve been fucking (.) signing off ambulances (.) for the last, you know, I don’t know how many- I mean- it’s just (.) you know, cos it’s not like (.) the people were doing nothing, the people were just seeing other sick people, ja. And sooner or later some sucker hh has to pay for it. Ja ... But (.) he was in resusc for a reason and there wasn’t any staff because three people were off and I’d phoned the matron and it’s the usual shit so basically there’s nobody on the floor so you put somebody in resusc and if I hadn’t walked in to do a gas I wouldn’t have even noticed that he wasn’t breathing.”

Dr S quickly assures me that, contrary to her prior statement that she is responsible for “every patient there,” she is not in fact responsible for the death of the man in question – “I mean, it’s not necessarily responsible for-”. Lest there should be doubt, she abdicates the story for the duration of the events that caused the man’s death, which occurred, she tells me, on the “previous shift.” While she alludes to the possibility of her causal responsibility – “I got a trachi in but not quick enough” – she does so only after ensuring that I will not be taken in by her ‘admission’, having already established the reason for the delay, namely that the man had waited eight hours prior to her arrival at the hospital. Establishing even more firmly the safety of her position as being well clear of any potential accusation, she proceeds to defend “the team in front of us,” implying their position as the only suspects and thereby denying her own possible responsibility. It was not *their* fault, she assures me – “(the patients) haven’t waited cos the team in front of us have been sitting (.) on their arses doing nothing.” “The people” I might suspect of the crime were in fact “just seeing other sick people” – hardly a reprehensible occupation. “And sooner or later some sucker hh *has* to pay for it,” a consequence of the natural order

²⁶ Tracheotomy tube – inserted to facilitate mechanical ventilation.

of things and therefore beyond the control of the “people” she defends and, by implication, even further beyond her own. In addition, his death was not only unavoidable – “he was in resusc for a reason” – but there were a variety of other factors preventing the doctors in question from saving the man, including the absence of some staff. In fact, she assures me on re-entering the story, her noticing that the man “wasn’t breathing” was itself, under the circumstances, surprising, alluding to the likelihood that she might not have – “If I hadn’t walked in to do a gas I wouldn’t have even noticed.” Far from having caused his death, therefore, the man died *in spite of* her actions – “(he) died *even though* I...got a trachi in.”

These assertions of innocence must be read, in the context of the doctors’ narratives, as unsolicited denials of guilt, thus suggesting the opposite possibility and producing a sense of too much protestation. I must emphasize here that the argument that I am making is not one for the doctors’ actual guilt but rather one for the guilt they impute to themselves, a guilt produced not by their actions but by their unrealistically inflated construction of themselves, within the narratives of science and of masculinity, as all-powerful agents.

Guilt and blame

Assertions of innocence, however, are insufficient to conclude a case and agentless constructions leave room for a continued search for the culprit. Amongst the functions of the cohesive ‘us’, distinct from ‘them’, described in the preceding chapter, appears to be the maintenance of positive self-evaluations through the construction of a target for blame. Consistent with the pairing of the concepts of collegiality and uncertainty throughout the literature that deals with the fraternal nature of the medical profession, this component of the Greenland doctors’ self-presentations appears to serve as a defence against an unspoken but ever-present implication of the possibility of their incompetence and failure, and against the associated recriminations. The following story, told by Dr J, illustrates her transition from self-doubt to blame, the mechanism by which she is able to conclude the case for her innocence of a failed attempt to resuscitate a patient:

“You are with that person and you try- you are doing your utmost. And if they don’t make it you know you’ve done your everything. (.) But you still feel (.) you know (.)

upset about it. You still go- like for me I still go in my mind I'm like- I'll talk to someone about it and I'll say, 'Look, (.) this was the case (.) is there any- did I miss something? (.) So, you're like, 'Ok, this is what I did, he came- this is how he came in, this is what happened, this is (.) uh what I did and this is what I did next, da da da da da. And (.) in most instances he'll say, 'Look, um (.) you did everything you could, da da da da da'. But still you feel there's- (.) maybe there's something you could have done. (..) I think it's only human. (..) You think like, hmm, is there something else that you should've done, is there- (.) did I miss something? Should I have done something faster? Is- (.) you know, should we have acted on this a little bit faster? If we had picked that up earlier would it have made a difference? (.) So- (.) Usually I would speak to, if not someone working here, someone else who's also in- doing the exact same thing that I'm doing. (.) and just (.) you know, tell them, 'Look here, I- I um- (.) For instance there was a guy this week. Um (.) he had one thing (.) and (.) we kinda didn't pick it up. (.) Um (.) and he- and we assessed him as being something else. Also something urgent. And- we were wait- we were going to send him over to Bluewater. (.) Um (.) the guy was inevitably gonna die. (.) Based on what he had... He basically came in and (.) what he had was a- his aorta was dissecting. (..) His aorta was splitting. It was ripping. And the way we w- like I- you get what is known as like a typical presentation of patients. This man was not fitting in with my typical presentation. (.) Um, he had- his main complaints was completely different to what we have been taught (.) as being (.) patients' main complaints. And he had sort of like the lesser (.) complaint of- of- like- You get a list of complaints and the one at the bottom- now that bottom one? That was the one that he complained of. And he had some subtle thing. And as I say, retrospect you always have twenty-twenty vision retrospectively. Your retrospective vision is always twenty-twenty. Cos now you go- cos I know the guys that came on, they like, 'How did you miss it?' I'm like, 'Ja, you know what? If you were there you would have missed it'. Because of what he complained of. (.) Cos it wasn't just me it was like other doctors that also examined the guy and they didn't pick it up either. (..) On his way, before he got to Bluewater he died. (..) Uh cos the ambulances take so long- Oh! Other source of frustration. Ambulances. (.) They take too long to come. It's a massive frustration. We need to transfer a patient urgently to another facility (.) they just don't come. (..) They just say, 'No, we don't have an ambulance

available'. (.) and then the ambulance brings in rubbish like sore throats (.) and uh (.) diarrhoea for a month or whatever (.) and you go like 'Uhhhh'. (.) Cos their reason is the person is already at a hospital so there's less urgency for that person to go to another facility. And if you say you need a paramedic you gonna wait even longer. Cos there's very few paramedics in state."

As invited by the narrative framework placing doctors in the position of all-powerful agents, Dr J describes the failed resuscitation and death in terms of her own actions – “this is what happened, this is (.) uh what I did and this is what I did next, da da da da.” Beginning by assuring me that she has done her “utmost” and her “everything” to save the patient, Dr J portrays her anxious response to a patient’s death as understandable but nevertheless unwarranted – “You *still* feel ... upset about it.” Invoking the assurances of another doctor, she proceeds to assuage her own doubts by supplying his answers to her questions – “Look ... you did everything you could’.” Shifting the focus from her misgivings about her actions to what appears as a surrogate doubt in the understandable nature of these misgivings, she proceeds to assure me that these doubts are “only human,” the unstated implication being that their unwarranted nature is a given. The list of the doubts she goes on to relate seems to highlight their unreasonable and self-penalising nature, as well as foregrounding the possibility that a better performance may have made no difference. In the example she supplies, however, she continues to display discomfort with her error, preceding its statement with ‘kinda’, a word that diminishes the reality of what she admits – she (only) “*kinda* didn’t pick it up.” Interrupting the sequence of events to assure us that “the guy was inevitably gonna die,” and to emphasize the horrific (and thus presumably incurable) nature of his complaint – “His aorta was dissecting. (.) (it) was splitting. It was ripping” – she justifies the error by accentuating the atypical nature of her patient’s presentation, again apparently anticipating the accusation that she should have seen it. She goes on to assure us that to see the man’s complaint would have required “twenty- twenty vision,” and that “it wasn’t just (her)” – “If you were there you would have missed it,” her unprompted disavowal alerting us to her own self-doubt. By the time that her story reaches the event of the man’s death, she has led us to the real cause, distal from herself – “he died ... cos the ambulances take so long.” Her sudden

exclamation – “Oh! Other source of frustration. Ambulances” – creates the sense that she has found what she herself has been searching for, illustrating employment of the defensive reactions that authors including Good and DelVecchio-Good (1993; 2000), Dartington (1994), Oberholzer (1994), Mizrahi (1986), Mishler (1984) and Goffman (1961) have described, namely a cause for the man’s death that diverts attention from herself, having brought another actor to the fore – “They” who “take too long to come,” “just don’t come,” “just say, ‘No, we don’t have an ambulance available’,” and “bring in rubbish like sore throats.”

Not only, therefore, do doctors disappear as actors in their unhappier stories but, in keeping with the substantial discussions of authors including Good and DelVecchio-Good (1993; 2000), Dartington (1994), Oberholzer (1994), Mishler (1984), Mishler et al. (1981), Goffman (1961), Paget (1988), Rosenthal (1995), Wodak (2006b), Szasz and Hollender (1997) and Zagier-Roberts (1994), who identify blame as that defence most used by members of the medical profession, a host of other agents suddenly appear. Other hospitals are blamed for not carrying their share of the patient burden – “If (name of hospital) wants us to deal with all of it then- (.) then this is exactly what they must expect.” Nurses at Greenlands, usually backgrounded in the doctors’ talk, come to the fore. And doctors from other hospitals are identified as culprits. When no single agent present can be found to take the blame, it is shifted either to the minister of health – “You’ve got a minister of health who’s nick-named Dr Beetroot²⁷. That just about says it all!” – or onto an environmental cause – “Ja, I think that the stress of the job, (.) the work environment (.) the lack of staff (..) the burden of patients and how ill they are (.) and you start treating them as entities rather than as humans.” Alternatively, the cause is identified as a quality of the place itself, rather than resting in the actions of those who inhabit it – “This place is actually pathological.”

²⁷ Manto Shabalala Msimang, the Minister of Health at the time that this research was conducted, was well known for her statement, at a time when the department of health was resistant to making antiretroviral drugs available to patients suffering from HIV and AIDS, that beetroot was a good alternative treatment.

Blameworthy patients

As noted by a number of authors writing on the subject of blame within medical culture, most frequently of all it is the patients themselves who take the blame for the myriad of adverse events that take place in the unit, including their own illnesses, their failure to get better, their doctors' inadequacies (Mishler et al., 1981) and even their doctors' feelings of hostility and aggression toward them (Mizrahi, 1984; Zagier-Roberts, 1994).

When a doctor has failed to obtain an adequate history from a patient this is typically reported on the ward round in terms of the fact that "(the patient) doesn't give a good history," attributing sole responsibility to the patient for what can only have been a two-way communicative endeavour. Not only is the poor quality of the history construed as the patient's fault, this fault is actually her inherent characteristic – not only *did* the patient not "give a good history" on a particular occasion but she "*doesn't*" give one in a more generalised sense, further denying the dialogical process. When a patient leaves the hospital without an adequate understanding of his illness and treatment it is he who is primarily responsible:

"Sometimes I tell people exactly what's going on. And they have been asked five minutes afterwards and they go, 'Oh, no, he just told me to take a pill'."

Since the doctor's actions are irreproachable – "I tell people exactly what's going on," the only cause for the patients' subsequent lack of the relevant knowledge can be the "people" themselves, who are the more reprehensible for denying the doctor's efforts – "he *just* told me to take a pill." In fact, patients in general "*don't* take responsibility for their own health."

My reply to Dr P's statement to this effect elicited an interesting response:

I: Ja, I mean, I agree with you, one has to take responsibility for one's own health, but if you look at the way health care is provided (.) generally patients aren't given the necessary information and so on.

J: Yes. Absolutely. Cos we expect them to take responsibility for their own health but then we say, 'Take this tablet'. 'Take these tablets and you'll get better'. We don't say

this one's for this and this one's for this, we're like, 'Put your arm up there' and you shove a pipe into their chest and before they know it they're like, 'What the hell's going on?' (.) They feel better, therefore they're like, 'Oh, you helped me. (.) But I won't ask questions'. (.) You know.

Dr P begins by expressing full agreement and even citing the errors of the doctors' ways. Once he has "shove(d) a pipe into their chest," however, the patients begin to "feel better," justifying the doctors' actions and even producing gratitude – "“Oh, you helped me.” Having thus 'proved' the positive nature of the doctors' actions, he then quotes from the patients' minds – "But I won't ask questions," effecting a subtly produced exchange of positions and reaching a conclusion in which the patients have become the culprits – it is they who "won't ask questions."

On those occasions when it is the doctors' actions themselves that are the source of concern, these are construed as reactive to those of their patients, mirroring the constructions discussed in the previous chapter in which patients' agency is denied, and illustrating the "powerful mix of blame...and professional leniency" that Rosenthal (1999: p. 162) describes. Standing at the foot of an apparently unconscious woman's bed, Dr N asked Dr D,
 "Did you put her to sleep?"
 "She kicked us," Dr D replied, her affirmative indicated only by her substitution of a direct answer with a description of the patient's (prior) kick, justifying what becomes her *reaction*.

Dr F, elaborating on the reasons for which she would "probably end up telling the patient she's got pneumonia and discharge her with amoxicillin – not because that is what I really really think but because she wants an answer," (see chapter seven) offers a description of the consequences she would incur at the hands of her patient's family should she have told the truth, justifying her lie – this time by means of her patients' anticipated actions:

“The family will probably take her to another doctor tomorrow just so they can say they came here and she was just sent home with these pills and she’s still sick. Just because I can’t tell her anything concrete.”

Patients are blamed for their own illnesses too. Frequently, the patient’s behaviour is identified as the most relevant aetiological factor. The doctors may well, on occasion, be correct in this assessment and it is arguable that patients should be made aware of the role they have played. Dr Z asked a patient,

“How much do you drink?”

“Not much,” the man replied.

“What do you drink?” the doctor persisted.

“Brandy.”

“Alright,” said Dr Z, “You’ve damaged your liver now. You’re going to have to stop drinking. Immediately.”

In a similar but arguably less productive instance of citing the role played by the patient’s behaviour in causing her illness, Dr P, after informing the sister of a woman he had (mis)diagnosed as having suffered a stroke that she was going to die, launched into an angry tirade:

“She was told if she didn’t have her feet off she would die and she refused. And now she is gonna die. Then that’s her decision. She should have had the amputation. I mean, I’m blunt with people. I tell them, ‘If you don’t have your feet off you’re gonna die’. And now she is gonna die.”

The combination of Dr P’s anger and his simplistic construction of the woman’s “refus(al)” to have her feet amputated implies more than an intellectual commitment to the belief he is professing. In fact, his words produce a sense of urgency in his attempt to convince me, and perhaps himself, that the impending death is the fault of the dying woman. His simplistic construction of what can only be assumed to have been a very difficult and emotionally fraught decision seems a glaring omission of the complexities that must surely have been involved and indeed a denial thereof, rather than a simple

oversight. The anger with which he made his point further convinced me of the truth of this interpretation, provoking a suspicion, through overstatement of his case, that he ‘protest(s) too much’. I believe that his subsequent shift of tack, from a denouncement of the patient’s “decision,” to an assertion of his own provision of the information necessary to make the ‘correct’ choice in such instances, provides the clue to the reason for the doctor’s pressing attempt at conviction. It appears to indicate (and to attempt to avoid) once again the possibility of the opposite, namely that the death is not in fact the patient’s but the doctor’s fault.

On other occasions the role played by patients’ behaviour is less clearly defined. But their doctors are no less convinced of its relevance. Dr M, speaking of the reason the patients lying in the beds around us were ill, commented cynically the day after Christmas, “‘Tis the season to be jolly. Everyone’s rocking up and down!” Dr B, of obese patients, told me he disliked treating them because, “They’re the agents of their own demise.” And Dr P, of a woman who had suffered a hypoglaeamic coma, comments that, “She’s probably ‘fried a few brain cells,” the patient thus becoming the agent of the “fry(ing).” In cases of injury due to assault, the doctors tend to assume that the patient’s own antisocial behaviour was the precursor to the attack:

“I assure you that guy was not beaten up for no reason – that guy looks skelm²⁸. There’s very few people who are beaten up for no reason. Even the community beatings. There’s no way a community would just do that. They’re not innocent.”

And Dr I asked his patient, who had been stabbed in the abdomen, “Did you do anything to warrant the attack? (..) Did you rob someone or anything like that?” looking at me askance when the reply came in the negative.

Not only the patients’ behaviour is faulted but their characters and characteristics too come under scrutiny. Paralleling Goffman’s (1961) description of the hostile characterisation of patients in total institutions as bitter, untrustworthy and secretive, patients who have taken their medication incorrectly or not at all, failed to follow their

²⁸ Afrikaans slang word implying slyness, dishonesty and some criminality.

doctors' orders in some other way or who have presented very late in the course of their disease, are constructed by the doctors of the Greenlands emergency unit as stupid, ignorant, irresponsible and irrational. Dr L asked her colleague, "Why is he drinking if he's an epileptic?"

a question directed at eliciting an indictment of the patient, and to which her colleague responded by tapping his head with his index finger, implying stupidity, irrationality or both.

Dr P comments on the large number of patients brought to the hospital in a very advanced stage of illness or after having failed to take prescribed medication correctly:

"You know, but again, it's- I mean, who's (.) fault is it that (.), you know, is it the (.) health system's fault that the patient stayed at home for hh six months getting worse and worse and worse and worse before he was taken to us? Maybe there wasn't a readily available doctor or something. Or maybe- ja. But maybe it's ignorance on the patient's part. 'What- what- what tablets are you taking?' You know, 'What tablets are you taking?' 'Oh, I don't know'. 'What's the name of the cigarettes you smoke?' 'Rothmans'. 'So you can read'. So therefore, 'Why don't you know the name of your tablets?' Cos if you don't know the names of your tablets you're probably not taking them. Which I find inexcusable. Cos- And it's a complete move of responsibility for their health onto someone else. Onto the health care providers. Which is wrong. But that's (.) the way it's been. You know, um-"

Dr P begins by introducing a search for the culprit – "who's (.) fault is it?" – which he follows immediately with a suggestion that draws our attention to the illogicality of blaming anyone other than the patient himself – "is it the (.) health system's fault that the patient stayed at home for hh six months getting worse and worse and worse and worse before he was taken to us?" As the only agent in this construction, the patient is the only possible culprit. It was, after all, he who "stayed at home." This action having occurred prior to the patient's being "taken to us," it is logically impossible for his demise to be "the health system's fault." While Dr P acknowledges that "Maybe there wasn't a readily

available doctor or something,” his subsequent suggestion, “But maybe its ignorance on the patient’s part,” makes use of the word, “but” to shift the spotlight away from this possibility and to refocus attention on the patient’s “ignorance.” Rendering this possibility all the more convincing, the doctor proceeds to construct an image of the patient as someone who does not even know what medication has been prescribed for him. However, he goes on to suggest that the patient’s “non-compliance” is more culpable than would be implied if ignorance were the only contributing factor, indicated by the fact that he can read the brand name on his cigarette box and presumably, therefore, the details of his medication. Dr P thus sets the scene to convince us that it is in fact “inexcusable” behaviour on the patient’s part that has led to his current illness, further emphasising the moral unacceptability of his failure to assume responsibility for his own illness and thus completing the “health care providers’” vindication and firmly establishing blame within the patient’s arena.

Subjects and objects, victims and perpetrators

Not only, however, are patients simply construed as to blame for adverse events in the unit, they are in fact depicted as dangerous, both to themselves and to those around them, including the doctors. Thus, the doctors’ relinquishment of their own agency in order to blame their patients for adverse events effects the role reversal that Katz (1984) describes, in terms of which doctors bring into being the “world of contradictions wherein the patient (is) oppressed while being characterised as the oppressor” (Mizrahi, 1986, p. 35) and, I argue, along with Mizrahi, is in turn subjected to abuse. No longer objects devoid of any capacity for action, patients become the culpable causes of every problem. In the process, the doctors deny their own agency or render their actions ineffectual, unable to deter their patients from their irrational, irresponsible or malicious behaviour. In those instances in which patients are blamed for the doctors’ actions, however, passivity is not always sufficient proof of the doctors’ innocence. Doctors and patients are therefore pushed even further toward their opposite poles, doctors becoming their patients’ victims, driven by them to behave in the ways that they do. The ‘real’ perpetrators, the patients, are constructed as “literally harassing” their doctors, “circling

(them)” (like helicopters), “conspiring to irritate (them),” “wasting (their) time,” and generally “mak(ing) (their) lives difficult.” Dr L describes their relationships as she sees them:

“You know, that’s the other thing. You try’na help someone and they swearing at you. (.) And they being abusive to you. And you just gotta deal with it.”

Proceeding with an example, she describes her interactions with a young boy who had been hit by a car and had his leg broken:

“He was very, very obnoxious. He was rude, he was swearing at us (.) um, you know, while we trying to help him.”

While I have little doubt that the boy was indeed “swearing at (her),” and that she was “trying to help (him),” his construal as the aggressor and hers as his innocent victim seems at least one-sided in light of her response to my subsequent question:

“And d’you have any idea why he thought he was swearing at you?”

“Well because-” she replied, “Well, the thing is we- (.) his leg was painful (.) and we were moving his leg. We had to move his leg cos he had a massive gash there as well that needed - that I needed to- to suture. (.) Um (.) and I needed to get to the wound. (.) and I gave him sedation and that kind of also- sedation also lowers your inhibitions. So- (.) he was just swearing at us, you know, and um- (.) He was becoming very- he was fighting and uh we had to get a porter to hold him down and even then it wasn’t helping.”

In her initial description of the boy’s behaviour Dr L did not tell me that he was in pain and that, in order to treat him the doctors had to make his pain worse. Nor did she reveal that the boy had been given a sedative, which may have lowered his inhibitions, reducing his motivation to control his behaviour. While she admits in her reply to my question that “we were moving his leg,” she makes no causal connection between this action and the boy’s distress. Instead she construes these as two independent facts – “his leg was painful (.) *and* we were moving (it),” the conjunction ‘and’ implying an association between the movement and the pain but not a causal one. Dr L also gives no indication of her and her colleagues’ involvement in the “fight.” It was “*he* (who) was just swearing (and)

fighting,” the word ‘just’ suggesting an absence of motive. Her own and the other doctors’ actions, on the other hand, are justified by necessity – “We had to move his leg,” “I needed to get to the wound,” and “we had to get a porter to hold him down.” While these necessary actions were motivated by the doctors’ intention to “help” the boy, they were, she reminds us, nevertheless ineffectual, once again demonstrating the doctors’ new position of impotence – “even that wasn’t helping.” Reading between the lines and surmising some causal connections myself, however, the picture can be altered dramatically with no great stretch of the imagination. Instead of the “very, very obnoxious” boy Dr L describes as “abus(ing)” his doctors, it becomes quite easy to envision a boy in excruciating pain, who has been made somewhat irrational and uncontrollable both by the intensity of the pain and by the sedatives he has been given. From this point of view, it is quite plausible, then, that to him his doctors would have seemed the aggressors and he their helpless victim, pinned down by a porter and subjected to unbearable torture, highlighting the distortion in the doctor’s construction.

Doctors portray themselves as the victims not only of verbal abuse from their patients but also of physical violence. Dr P describes the extent of patients’ violence in the unit: “Two doctors, two nurses and two patients have been assaulted in the last three months by psychiatric patients. (.) One patient sexually assaulted- two patients sexually assaulted. (.) In the casualty. By psychiatric patients.”

And Dr R elaborates the threat that these patients pose:

“But apart from anything it’s dangerous to us and it’s dangerous to the other patients. That’s the big thing. I mean you get- you get these aggressive guys coming in and you sedate them ok fine, but then they wake up on the sly, go sneaking around the hospital, and the next thing you know he’s raped some woman in a ward (.) or (.) you know, something really terrible. (..) You know, these guys wake up and they literally (.) sneak past you. (..)They- they sneaky, they really are.”

While no reason exists to doubt the accuracy of the figures Dr P provides, and Dr R’s claim that there is a risk to both doctors and patients would be difficult to deny, a number

of features of the doctors' talk on this topic render it nevertheless an aspect worthy of discussion. Firstly, descriptions of patients' violence toward doctors exist in the absence of similar descriptions of doctors' violence toward patients, which are not uncommon. Only once during the time that I spent at the hospital did I hear a doctor make mention of such an event – “You should have been here on the weekend!” he laughed as we watched his colleague's rough treatment of a man he was attempting to sedate. “One of the doctors hit a patient! The man was drunk and the doctor lost it and klapped²⁹ him!” Secondly, doctors' portrayals of their patients' violence tend to depict them as motiveless, driven by irrationality, as in Dr L's description of the “very obnoxious” boy above and Dr P's failure to mention Dr J's attempts to perform a lumbar puncture against her patient's will in his narration of the story in which the patient hit Dr J. Alternatively, patients' violence is depicted as the product of pure malice, again independent of the interactions within which it occurs, as in Dr R's description above of the “sly,” “manipulate(ive)” and “aggressive” patients who “go sneaking around the hospital” doing “really terrible” things. While again not denying that terrible things do sometimes occur, nor the real malice and aggression of a patient who rapes “some woman in the ward,” my argument concerns the absence of *any mention* of what frequently occurs as part of an *interaction*, rather than as an action emanating from the relevant patient's evil intentions.

Thirdly, while again not denying the serious nature of some incidents, the doctors tend, in many of their stories, to exaggerate their patients' violence and the risk that they incur. An incident that illustrates the reason for which I began to question the doctors' proclamations of fear, and characterisation of their patients as frightening opponents, was one in which three doctors and two security guards chased, caught and sedated a man clearly suffering some mental disturbance. The man was thin and frail looking and, while the chase occurred all around me, the man at one point even seeking shelter behind me, at no point did I sense any threat either to my own safety or to that of anyone else. In fact, contrary to displaying aggression, the man appeared frightened of the doctors, and was certainly convinced that any threat was to himself. At that point during the incident when the man was caught and sedated, he did, however, make a most feeble attempt to hit the

²⁹ Hit (Afrikaans)

doctor holding the syringe, an attempt that can be described better as a flap of the hand than as an attempted blow. Watching this action and feeling pity for the man, I inadvertently muttered, “Shame³⁰.”

“Shame what?” retorted Dr P defensively, seated next to me at the doctors’ station.

I described what I had seen to provoke my sympathy.

“Did he try and hit him?” Dr P asked with great consternation, sitting up sharply in his chair.

I reiterated the pathetic nature of the attempt.

“That constitutes a threat, which needs to be suppressed!” he replied, jokingly refusing to be dissuaded of the danger and thereby suggesting the usefulness of this construction to him.

Caring for perpetrators

It is not difficult to imagine how such constructions might, as Mizrahi (1986) argues is the case, enable the delivery of less compassionate care, rendering patients less worthy, justifying avoidant behaviour on the part of their doctors and, in the words of Millman (1977: p. 202), providing the grounds for “the profession’s inclination to make the client at best a passive participant in the work – to, in essence, remove from the client his everyday status as an adult citizen, to minimise his essential capacity to reason and his right to dignity.” Indeed, a number of authors including Lorber (1975), Szasz and Hollender (1997) Paget (1988) and Zagier-Roberts (1994) have argued that constructions in terms of which patients are blamed for adverse events increase the likelihood that patients will be subjected to inferior care. Three key mechanisms whereby blame can be argued to facilitate inhumane care appear to be operative in the Greenlands emergency unit: first, blame conjures feelings of anger and hostility toward the patients, both rendering them less worthy of care and provoking and justifying acts of aggression on the part of their doctors; second, blaming patients involves the attribution of agency to them and hence constitutes a threat to doctors’ power, creating a need for its more vigorous reassertion; and third, blame defers responsibility away from the doctors, reducing their

³⁰ The word “shame” is used colloquially in South Africa as an expression of sympathy.

accountability for quality of care. In the remainder of this chapter I will detail and illustrate the workings of these mechanisms and the role of the associated constructions in reaffirming the positions of doctors and patients and in perpetuating the nature of the interactions between them, as forecast by the narratives of science and of masculinity.

Blame, hostility and quality of care

As illustrated throughout this and the preceding two chapters, the doctors in the Greenlands emergency unit regularly express feelings of hostility toward their patients. The relatively direct pathway between blame, these hostile feelings and the delivery of inferior care is illustrated in the following extract. Dr Q and Dr V, seated at the doctors' station, expressed their feelings for one of the patients with whom they were dealing that day:

Dr Q: We hate her. Woops, did I say that out loud?

Dr V: That's why she never got a chest X-ray.

Dr Q [To me, in explanation of what I had just overheard]: This woman epitomizes everything that's fucked up about this country. She went to a hospital in the Eastern Cape, where she was fully worked up and given an appointment to return in March last year. (.) She never went back. (.) Now she shows up in the Western Cape system. She's wasted R20 000 of the Eastern Cape's money and now she's going to waste R20 000 of our money.

While the "hospital in the Eastern Cape" is faultless, having "fully worked (the patient) up and given (her) an appointment to return in March last year," the patient herself "epitomizes everything that's fucked up about this country." She has "wasted" the money of the Eastern Cape's health system and is about to inflict the same damage to that of the Western Cape, providing ample justification for denying her a chest X-ray. While there was a hint of humour in this conversation and I cannot speculate about the clinical indications that the woman in fact required an X-ray, what is certain is that Dr Q is offering her demonisation as justification for his feelings of "hate" for her and for the delivery of inferior medical care.

The deficient care offered to psychiatric patients at the hospital, too, is justified by blame, the doctor this time invoking the threat that these patients pose to other patients:

“We don’t manage psychiatric patients here. Here we sedate them, tie them to the bed. (.) If they (.) stop breathing (.) bonus.(..) You know, that’s what happens. You don’t interview them half the time (.) uh- You know, you don’t give a shit. They (inaudible), you just bash them on IV, sedate them, chuck them on a bed and then (.) if they keep on getting rowdy then you send them off to (name of psychiatric hospital) and if they don’t, well then in three days time you boot them out and just wait for them to do it again. (.) It’s not managing psychiatric patients. Cos they’re so disruptive. And the problem is that (.) they (.) skew (..) the treatment of patients um (.) because they are so intensive in terms of their time and then- So (..) somebody could come in stabbed in the belly (.) but a psychiatric person’s gonna be making such a rumpus that you’ll have to sort him out first. Before the stab belly. Now that’s- it’s absolute- that’s wrong. Should they even be brought here? I’m sorry. (..) You can- y can ask any one, you ask any doctor who’s worked in the casualty here. (.) And (.) probably, well- one of the first things he’ll say to you is (.), ‘Ja, the psych patients (.) ja, we take them down’.”

Dr W, in this extract, describes the frequently appalling treatment of psychiatric patients, following it with a causal explanation that foregrounds the patients’ behaviour and its consequences for other patients. When another patient who needs immediate treatment has to wait while the doctor attends to the psychiatric patient, the doctor’s action is described as determined by that of the “psychiatric person” and devoid of his own choice. Not only do the actions of the psychiatric patients have disruptive consequences, but they are morally “wrong,” provoking the reaction to which *all* doctors fall prey – “You can...ask any doctor who’s worked in the casualty here” – namely, applying the ‘take down’ of the psychiatric patients. Again, this insistence that “you can ask anyone” smacks of an unsolicited denial of the possibility that Dr W in fact attributes his response to his own personal failing, while simultaneously providing the justification for it.

Reassertions of power and the potential for abuse

In addition to projecting blame onto patients and others for negative events, and thus establishing their own innocence, the portrayal of patients as perpetrators and doctors as their hapless victims creates a need for doctors to assert and reassert their power, just as soon as they have renounced it. Having designated their patients as threats, the doctors must in turn suppress them, necessitating and justifying, for example, the patients' heavy sedation with valium, the tying of others to their beds and the "feral" reactions Dr P describes when facing the "threat(s)" he feels he must "destroy."

Dr J describes the procedure for sedating patients at the hospital, the patients' behaviour, and that of one in particular, requiring and justifying the extreme measures adopted: "There was another psychiatric patient, Delilah (.) Smith. (.) She was a regular here. (.) She's been a regular for a while and- and um (..) she went off one day, she pulled out her drip and she's the type of patient that gets a bit manic at times. And so she will sing and dance and perform in the casualty. So (.) I dunno (.) we were on night shift and it was about eight o' clock in the morning and- uh- she was just getting out of hand and when Dr Y comes he doesn't like the psychiatric patients running around. This was some time last year. And she (.) started to get aggravating, shouting and screaming. So we wanted to sedate her. But we need to get a drip up on her. (..) So first she kicked me in the bum (.) just walked up to me and kicked me in the bum. (laughs) I dunno if because my bum is so big everyone like goes for it, but um- She kicked me in the bum and I said, 'I don't like that. Please stop it'. So she was laughing there (.) and then I said, 'Right, we going to give you some medication'. She refused to take the medication so I- I asked uh- some of the male guys just to help me hold her down. (.) She got a hold of (laughs) Dr T (.) and tried to choke him. (.) So we eventually had to take her down, we had to trip her and force her onto the ground to hold her down and sedate her. (..) And I told- I told Dr E- I told Dr E, she was here yesterday, she came to visit, I told her um (..) when you work in Greenlands casualty (.) you do not get scared of sedation. You do not get scared in sedating patients. (..) I mean, a lot of people say, 'Oh, only use 10mg of valium,' and stuff like that. Here our standard dosage is 20 mg of valium and five haliperidol and you are going to go to sleep. (..) And if you wake up then we will give you more."

Dr J begins her story with a description of that particular patient, Delilah's, actions. The only agent in the story's introduction, which sets the scene for the doctors' subsequent actions, Dr J describes Delilah's actions as the result of "the type of patient" that she is and as wholly irrational and out of the blue – "She went off one day," "She ... *just* walked up to me and kicked me in the bum," and, "She *refused* to take the medication." The doctors' first action in the story is a direct consequence of the patient's prior action – "She (.) started to get aggravating, shouting and screaming. *So* we wanted to sedate her." Dr J, interestingly, connects her own next (polite and innocuous) request – "I don't like that. Please stop it" – to Delilah's kick with the conjunction 'and', apparently comfortable this time to leave the question of causality less clearly stated. No sooner do her actions become potentially controversial again, however, and she reverts to the safety of the conjunction 'so', more firmly placing causality in her patient's court – "She refused to take the medication *so* I ... asked ... some of the male guys just to help me hold her down," and, "She got a hold of ... Dr T (.) and tried to choke him. (.) *So* we eventually had to take her down." Preceding Dr J's statement of the high dosages of drugs she and her colleagues use to sedate their patients, this anecdote serves as justification for her admission. Dr J's emphasis of the word 'going' – "you are going to go to sleep" – reinforces this justification, implying the patients' resistance to sleep and cooperation. Even a further dose is threatened if the obstinate patients dare to wake up again – "*If* you wake up *then* we will give you more" – the doctors' projected action a consequence of the patients' anticipated one.

Thus, construction of patients as threats to themselves, to other patients and to their doctors, while rendering them momentarily powerful enemies, necessitates their suppression, providing the opportunity for doctors to re-establish their own power just as soon as they have implied their vulnerability. That these attempts to re-establish threatened power can and do, on occasion, lead to acts of abuse, are illustrated throughout the material presented in this thesis, perhaps the most striking example being provided by the story presented in chapter seven of the "Greenlands takedown," in which a psychotic patient's violent outburst necessitated the administration of a double dose of valium, strangulation and compression of the man's face into the stretcher.

Blame and accountability

In addition to provoking hostile feelings and feelings of vulnerability and exposure to threat, and thus, potentially, allowing the delivery of inferior care, blame, of both patients and other non-doctors, in combination with the existence of distinct, clearly bounded groups, as described in chapter eight, further protects doctors from accountability both for the inferior care that they sometimes provide and for their “feral” reactions to more exceptional patients. The conversation held around the doctors’ station about the death of a very young baby who had been brought into the unit the previous night, as detailed in chapter eight, is a case in point. This story reveals the manner in which the doctors participating in the conversations surrounding the baby’s death worked together to protect one another, presuming each other’s innocence, laying blame elsewhere and ultimately concluding that the incident had resulted from “stupidity,” as opposed to “negligence,” and therefore required no further investigation.

Another instance of medical error that ended in near disaster further illustrates the potential for blame to enable poor quality care to go unchecked: The same woman who had been (mis)diagnosed as having suffered a stroke, above, was wheeled into the casualty by her sister. She was unconscious and her toes were completely rotten with gangrene. After asking a number of questions, Dr P elicited from the woman that she thought her sister had had “a slight stroke.” He contradicted her:

“No. This is not a slight stroke. This is a big stroke. She is going to die.”

He then asked whether the woman would prefer to leave her sister in the hospital or to take her home. The woman insisted that she should stay in the hospital, clearly not understanding the doctor’s implication.

“Well, there’s no bed for her. She’s just gonna stay where she is here in the corner.”

Still not grasping the doctor’s meaning, the woman maintained that she would stay.

“Look, it’s your decision. It would be very difficult to look after her at home like this so I won’t blame you if you decide to leave her here – I’m just asking because sometimes the relatives want to be close.” Dr P then walked away from the bed. A few minutes later he returned, telling me that he was going to try, as a “last ditch attempt,” to “wake her up with some sugar.” Explaining to the woman’s sister and husband, who had joined her,

that “either it will work immediately or if it doesn’t that will not be a good sign. I’m sorry to be the bearer of bad news, but, ja, that won’t be good.” Moments after the injection, the patient woke up, lifted her head and began talking to her family members. There was an enormous sense of relief all round and Dr P was glowing:

“I gave the wonder drug and she survived.”

Still reeling from the emotional ordeal, I stammered, “that was-”

“Cool!” he interjected for me.

Only afterwards was the question raised of why the woman’s blood sugar levels had not been tested as soon as she arrived, which would have averted the near disastrous mistake. While the mistake was both that of the nurse who took the patient’s observations and the doctor, Dr P, who failed to notice the missing test result, first promising to provide no treatment at all and then proceeding to administer sugar without the blood glucose reading, only the nurse’s fault was ever implied. Dr P, on the other hand, revelled in the glory of having saved the woman’s life. Thus, in both instances, the presence of a host of targets for blame serve as immediately available causal factors in stories of adverse events, diverting attention from the doctors’ mistakes and other undesirable actions, completing the picture and thus obscuring the need for further investigation.

The cycle of guilt, blame and power

The retaliatory and suppressive actions the doctors describe, whereby patients are, for example, sedated or ‘taken down’, assist in the reestablishment of doctors’ temporarily forfeited power but are the very same actions that produce, through their potential to provoke criticism, the sense of self doubt that originally necessitated patient blame. This brings the doctors back to the beginning of what has become a vicious cycle. Defined as all-powerful and faced with a situation in which failures are inevitable, doctors find themselves caught in a ‘narrative trap’, in terms of which they must either accept responsibility for disease, death and abuse, an option that would strip them of their integrity and of the possibility for positive self-evaluation, or refuse the only positive identity available to them within the discursive framework, namely that of the all-

powerful doctor. The emerging pattern of patient blame can thus be seen as a defensive manoeuvre, allowing the doctors at least partially to escape the self-doubt arising from the contradiction between their narratively structured expectations and the realities of the Greenland's emergency unit, and simultaneously to affirm their continually threatened sense of power. These affirming actions that blame enables, however, are no different from those it attempts to escape, thus contributing toward a repetitive cycle in terms of which the doctors' position as all-powerful agents, along with the associated responsibility and consequent self-doubt, is produced and reproduced

Summary

Again, this chapter has made use of disparate themes represented in previous research as prominent components of medical culture and has illustrated the animation of these in the Greenland's emergency unit, showing how they might contribute to the delivery of inhumane care. With reference to themes including the god-like power ascribed to doctors (Millman, 1977; Mizrahi, 1986; Fox, 1989; Good, 1994; Obholzer, 1994; Kellerher, Gabe and Williams, 1994; Van der Geest, 2005); the simultaneous inevitability of medical failures (Atkinson, 1981, 1984; Katz, 1984); Allsop & Mulcahy, 1999; Finkler, Hunter & Iedema, 2008); the attribution of responsibility in medical settings (Freidson, 1970; Katz, 1984; Fisher, 1984; Obholzer, 1994; Speck, 1994; Atkinson, 1995, 1999; 2004; Maynard, 2003); blame (Mishler et al., 1981; Mizrahi, 1984; Zagier-Roberts, 1994; Rosenthal, 1999) and the construction of patients in terms of hostile stereotypes (Goffman, 1961; Millman, 1977; Fisher & Groce, 1985; Mizrahi, 1986; Atkinson, 1995), I have argued in this chapter that the positions occupied by doctors and patients, as outlined in the two preceding chapters, are not as static as they appear at first glance. They are interchangeable, to a certain degree, in response to the doctors' need to evade responsibility for negative events, a responsibility imposed by their narrative characterisation as all-powerful agents. The discursive patterning, in terms of which doctors establish their innocence of these occurrences, and in support of which their patients' guilt, necessitates that they temporarily renounce their agency, leading to the calling in of their patients and others as the primary actors, in those scenes with unfavourable outcomes or portraying unfortunate events. I have argued in this chapter

that blaming their patients enables the delivery of inferior care by inspiring anger and thereby justifying poor treatment; and by denying doctors' responsibility and protecting them from processes whereby they might be held accountable for their less praiseworthy actions. In addition, this defensive move requires that they reassert their power in order to regain their 'rightful' position as doctors within the narratives of science and of masculinity, inciting them to suppress their patients and simultaneously justifying the means of doing so. This brings the doctors back, full circle, to that point in the cycle at which they are automatically attributed responsibility for adverse incidents, inspiring further patient blame, renunciation, reassertion of power, and so on.

University of Cape Town

CHAPTER TEN

SUMMARY AND CONCLUSION

I began in this study with a question about the discrepancy that exists between legislation and ethical guidelines and practice in the provision of health care, and about how it comes about that health care professionals, and doctors in particular, perform actions that constitute inhumane care and even violations of their patients' human rights. In attempting to provide some insight into why this discrepancy exists, I focused in this thesis on the discursive context of an emergency unit in a South African hospital in which inhumane and abusive practices were performed with routine regularity.

This thesis is intended to contribute to answering these questions in two primary ways. First, by integrating themes in the existing literature on culture, identity and power in medical settings that pertain to the topic of abusive medical practice, I have attempted to provide a more coherent picture than was previously available. I have therefore detailed the interaction of the various themes identified in the literature on medical culture and specified their contribution to the establishment of 'pathways to inhumane care'. Weaving together the various, otherwise largely disconnected strands in this area of work, I have argued that previous research has identified, more often implicitly and even inadvertently, but at other times quite explicitly, a myriad of interrelated factors that enable and encourage inhumane practices by members of the medical profession.

Second, using an eclectic mix of methods in order to highlight the interaction of this network of threads, I have illustrated the manifestation and enactment of these and related themes through the details of talk in a particular health care context, namely that of a South African public sector emergency unit. I have further extended understanding of the relevance of the variety of themes identified in the existing literature on medical culture for inhumane practice, exploring the range of actions that they make available to doctors in the Greenlands emergency unit and articulating the relationships between identified features of medical culture and violation of patients' rights in the context of this particular hospital.

Summary of findings

The literature

In the first five chapters, in which I reviewed the literature pertinent to the arguments presented in the empirical chapters, I have attempted to weave together disparate themes that span a broad range of research, including areas of work located within medical sociology, medical anthropology, medical education, social and individual psychology, and health systems research. These themes also represent work undertaken from a wide variety of theoretical and methodological perspectives, ranging from positivist employment of quantitative research methods to constructionist uses of conversation and discourse analysis. Since the areas of work represented in this review are therefore disparate, and since their relevance for the delivery of inhumane care with which this thesis is concerned is often only implicit or even indirect, my aim in reviewing the literature addressed in these chapters was to delineate a field that, while diverse in content and approach, has relevance for understanding the routine perpetration of abusive and otherwise inhumane acts in the practice of medicine.

In the first review chapter, chapter two, I have therefore attempted to identify threads in an amorphous mass of literature describing the various components of medical culture and its relationship with the broader social context. In particular, I have identified themes that explore representations of scientific, religious and traditionally masculine discursive constructions in medical culture, highlighting the propensity for some of their features to facilitate acts of inhumane care. With reference to the predominance of scientific discourse in medical culture (Mishler et al., 1981; Mizrahi, 1986; Arney & Bergen, 1984; Mishler, 1984; Fisher, 1986 and 1995; Fisher & Groce, 1990; Waitzkin, 1991; Dreyer & Geist, 1993; Wodak, 1996; Donnelly, 1997; Lewinsohn, 1998; Good, 1994; Good and DelVecchio-Good, 2000; Helman, 2001; Apker & Eggly, 2004; Potter & McKinlay, 2005), I have focused in particular on discussions of the objectification of patients and its potential effects on medical practice (Goffman, 1961; Lorber, 1975; Mishler et al., 1981; Mishler, 1984 and 2005; Katz, 1984; Mizrahi, 1986; Good & DelVecchio-Good, 1993; Dreyer & Geist, 1993; Turner, 1995; Atkinson, 1995; Donnelly, 1997; Hak, 1999;

Helman, 2001; Savett, 2002; Rothman, 2003; Potter & McKinlay, 2005; Heath, 2006). I have further explored discussions of the similarities between religious discourse and certain elements of medical discursive practice (Millman, 1977; Mizrahi, 1986; Fox, 1989; Good, 1994; Obholzer, 1994; Kellerher, Gabe and Williams, 1994; van der Geest, 2005). In this regard I have focused on discussions of the omnipotence, authority and infallibility ascribed to doctors and of the coexistent uncertainties of medical knowledge and its application (Fox, 1957; Atkinson, 1981 and 1984; Katz, 1984; Allsop & Mulcahy, 1999), attempting to highlight the propensity for these interrelated features to facilitate the perpetration of inhumane acts. And with reference to the presence of traditionally masculine constructions in medical discourse (Arney & Bergen, 1984; Mizrahi, 1986; Fisher & Groce, 1990; Cassell, 1992; Konner, 1997; Drife, 1998; Wicks, 1998; Erickson, 1999), I have traced linkages in the literature between, for example, the employment of military metaphors and the importance attributed to action with dramatic impact and the devaluation of caring acts.

In the second review chapter, chapter three, I have identified themes that pertain to the construction of identity in medical culture, as they appear in previous work. In so doing, I have discussed the centrality of the doctor's identity of bioscientist within past explorations of medical culture (Millman, 1977; Good & DelVecchio-Good, 2000), highlighting the relationship between the desirability of this identity, the power with which doctors are imbued as a result of it and the associated need and ability to conceal flaws, including, for example, uncertainty or error (Obholzer, 1994). I have reviewed in this chapter discussions of the collective nature of medical identity (Mizrahi, 1986; Fox, 1989; Good & DelVecchio-Good, 1993; Wodak, 1996; Erickson, 1999), highlighting the relationship between this particular form of collegiality and the inadequacies of the accountability of the medical profession and its members (Millman, 1977; Mizrahi, 1986; Paget, 1988; Fox, 1989; Rosenthal, 1995 and 1999; Allsop & Mulcahy, 1999). I have further explored in this chapter discussions of the binary construction of doctors' and patients' identities (Goffman, 1961; Katz, 1984; Fisher, 1986; Mizrahi, 1986; Fox, 1989; Dreyer & Geist, 1993; Zagier-Roberts, 1994; Wodak, 1996; DelVecchio-Good & Good, 2000; Rothman, 2003; Maynard, 2003; Andersen, 2004) and of the associated

stereotyping and labelling of patients in medical discourse (Goffman, 1961; Millman, 1977; Strong & Davis, 1978; Fisher & Groce, 1985; Mizrahi, 1986; Atkinson, 1995), attempting to highlight the resultant potential for inhumane care, a possibility that is rendered more likely through the related effects of the psychic defences available within medical culture and discussed by authors including Fox, 1957; Lorber, 1975; Mishler et al., 1981; Katz, 1984; Mizrahi, 1984, 1986; Obholzer, 1986; Paget, 1988; Cassell, 1992; Zagier-Roberts, 1994; Dartington, 1994; Szasz and Hollender, 1997; Good & DelVecchio-Good, 2000; Wodak, 2006b; and Iedema, 2007.

In the third review chapter, chapter four, I have identified threads in the literature that are relevant to the medical profession's institutionally based power and to the individual and interpersonal aspects of power as it is enacted between doctors and patients. In particular, I have explored discussions of the superior status ascribed to medical knowledge (Millman, 1977; Borges, 1986; Waitzkin, Katz, 1984; Arney & Bergen, 1984; Turner, 1995; Wicks, 1998; van der Geest, 2005) and highlighted the sense in which it places medical practices beyond question and therefore beyond scrutiny by anyone outside of the profession (Freidson, 1970a, 1970b, 1975; Millman, 1977; Borges, 1986). Identifying the usefulness of the albeit often implicit concept of agency for establishing the relationship between discussions of power and the possibility for inhumane care, I then turned in this chapter to an exploration of discussions of the power imbalances between individual doctors and patients. In this regard I focused in particular on investigations of patients' domination by doctors, through their access to supposedly superior knowledge (Millman, 1977; Katz, 1984; Mishler, 1984; Arney & Bergen, 1984; Fisher, 1986, Mizrahi, 1986; Silverman, 1987; Phillips, 1996; Szasz & Hollender, 1997; Wicks, 1998; Armstrong, 2002; Fainzang, 2002; Costello, 2002; Luftey, 2005; Finkler, 2008), and through the mechanism of blame (Katz, 1984; Fisher, 1984; Maynard, 2003). I further explored discussions of patients' own complicity in their oppression (Fisher, 1984; Fisher and Groce, 1990; Dreyer & Geist, 1993; Atkinson, 1995; Phillips, 1996; Szasz & Hollender, 1997; Gill, 1998; Perakyla, 2002; Heath, 2006), and subsequently of their resistance to medical domination (Fisher, 1984, 1986, 1991; Heath, 1992; Atkinson, 1995; Maynard, 2003; Mishler, 2004; Zaman, 2004; Tanassi, 2004; Perakyla, 2002,

2006). In this regard, I noted the relevance of the work of authors including Katz, 1984; Fisher, 1986; Fisher & Groce, 1990; Ten Have, 1991; Annandale & Hunt, 1998; Cicourel, 1999; Fainzang, 2002; Mishler, 2004; and Wodak, 2006a, who argue that patients' efforts in this regard often fail and/or fail to promote their best interests, leading, on occasion, to the delivery inferior medical care.

In the fourth review chapter, chapter five, I have addressed discussions of the importance of the influence of particular contexts on the actions of specific individuals, and attempted to show the relationship between these contexts and the features of broader medical culture reviewed in the previous chapters. To this end, I have reviewed discussions that address themes relevant to the manifestation or animation of the various features of medical culture and of their implications for the actions committed by individual doctors in particular settings, exploring these themes in the work of authors including Strong & Davis (1978), Mishler et al. (1981), Fisher (1986), Mizrahi (1986), Cicourel (1987, 1999), Helman (2001), Halford & Leonard (2006) and Finkler (1991, 2008). Having addressed these discussions of the relationship between the individual doctor, the particular setting and the features of the broader medical culture and institutional context, the chapter goes on to identify the importance of the growing field of hospital ethnography (see for example Wind, 2008; Zaman, 2004, 2008; Finkler, 2004, 2008; Warren & Manderson, 2008; Kelly, Pearce & Mulhall, 2004; Scheeres et al., 2008; Andersen, 2004; Gibson, 2004; Tanassi, 2004; Vermeulen, 2004; and van Amstel & van der Geest, 2004). Work in this genre represents a particularly rich avenue for exploring the relationships between the various themes reviewed, as they are animated by individuals operating within particular contexts, and the possibility for the delivery of inhumane care.

The chapter goes on to focus on work addressing the South African context in particular, reviewing discussions of medical culture, identity and power in the South African literature (Swartz, 1989; Muller, 1999; Gibson, 2004), and again highlighting its relevance for the possibility of abusive practice. This chapter further details research documenting the violation of patients' rights in South African medical settings (Swartz,

1989; Wood, 1997; Stadler, 1997; Mathai, 1997; Jewkes et al., 1998; Baldwin-Ragaven et al., 1999; Muller, 1999; Williams, 2000; Gibson, 2004; Levin, 2005a, 2005b; Lucas & Stevenson, 2005, 2006; Lund & Flisher, 2006; Fassin, 2008) and explores explanations in the South African literature for these occurrences (Jewkes et al., 1998; Muller, 1999; Baldwin-Ragaven et al., 1999; Gibson, 2004; Lucas & Stevenson, 2006; Fassin, 2008). While research in this area is very limited, this chapter notes the importance of the fact that its documentation continues into the very recent past, making a strong case for the relevance of research that attempts to explain inhumane care and hence to contribute to its prevention.

The empirical findings

After reviewing themes across this sprawling mass of literature that can be argued to be pertinent to an explanation of the relatively routine provision of inhumane care, I have, in this thesis, applied these themes in attempting to make sense of abusive and seemingly heartless practices on the part of doctors in the Greenlands Hospital emergency unit. In describing the interconnected aspects of the discursive context in the unit, I have highlighted their relationship both to the themes identified in previous research and to the abusive and otherwise inhumane acts that occurred during my period of observation in the unit.

In the first empirical chapter, chapter seven, I have attempted to show the ways in which the discursive environment in the unit, through its incorporation of features identified by past research as prevalent throughout the broader medical culture, promotes the adoption of dominant identities by the doctors and enables actions that would, under other discursive conditions, be unacceptable to both patients and staff, but that in this environment go almost unnoticed. In this chapter I have argued specifically that scientific and traditionally masculine discursive constructions, present throughout medical culture, as indicated by the literature reviewed, and predominant in the Greenlands emergency unit, are woven together within the unit's local culture to create overarching narrative structures through which the doctors interpret themselves and their patients, and the unit's events. I have drawn attention to the ways in which these narrative structures with

their various features are used by the doctors to position themselves as all-powerful, affording them superior and unquestionable status and presenting them with a multitude of opportunities for aggressive domination. Through the invocation of certain narrative ‘truths’ – for example, that scientific knowledge is superior to knowledge of any other form, that scientific activity is of unparalleled importance and that the features of traditional masculinities are indicative of strength and potency – non-scientific, caring activities are made to seem irrelevant. Hence, callous and even aggressive behaviours are more readily accessible to doctors than are displays of compassion. Thus, certain actions on the part of the doctors that might in other situations seem impermissible are rendered both possible and justifiable.

In this chapter I have further shed light on aspects of emergency room discourse discordant with the position of power available to doctors within this narrative framework. Resonant with much of the literature addressing this topic, I have identified what appears as the ‘underbelly’ of their powerful personas and have attempted to show that many of the discursive means whereby doctors establish and assert their power seem in fact to defend them against their own distressing emotional responses to disease, suffering and death over which they very often have little or no control. A great deal of the talk in the emergency room serves the purpose of boosting the doctors’ power. But a simultaneous narrative thread, the traces of which are audible in the ‘fleeting little words’ of which many of the doctors’ ostensibly bravado statements are composed, gives voice to their more vulnerable selves. Thus, there are occasions in which the emergency room doctors can be heard articulating the helplessness that they feel in the face of the often overwhelming realities that impact on their ability to successfully treat their patients. This counter discourse of powerlessness offers insight into the enormous difficulty of the position in which the doctors find themselves, opening the door to a more compassionate reading of processes that all too frequently lead to their abuse of power. Caught in a position, in terms of which enactment of the only positive identity available to them within the narrative framework depends on successful treatment of their patients and achievement of tangibly positive results, and in a context in which late attendance by so many patients and limited resources continually doom their efforts to failure, doctors find

themselves plagued by self-doubt. Thus, actions that appear at first glance to be nothing but callous, such as ignoring patients' pain or making jokes across the bed of a dying man, might be understood in much more complex terms as attempts to ward off emotions that, in the context of medical culture in general and of the Greenland's emergency unit's local culture in particular, they do not have space to acknowledge.

I note also in this chapter, however, that neither the discursive context of the broader medical culture described in the work of previous authors nor that of the local culture of the unit is deterministic. Rather, its inhabitants, including the doctors, remain free agents, choosing to enact, animate and reproduce the discursive structures that they embrace. Indeed, snippets of talk that can be heard about the unit confirm the possibility that doctors can and sometimes do employ other discursive constructions that diverge from the dominant narrative framework, enabling the adoption of alternative identities and facilitating actions that deviate from those courses most obvious within the this context.

In chapter eight, the second empirical chapter, I have offered an analysis of the subject positions that doctors and patients occupy relative to one another within the emergency unit's discursive context, discussing the ways in which doctors draw on the resources available to them within the broader medical culture, identified in past research, as they build their own identities relative to those they attribute to their patients. I have attempted to show how doctors and patients are construed in these terms as binary opposites, producing coherent and even antagonistic groups of 'us' and 'them', animated on a moment-to-moment basis in the unit by the individual doctors who work there, with implications for the interactions between them and their patients. As altogether different from 'us', patients' subjectivity is obscured from view. And as subjectless entities, patients are, for example, not addressed by their doctors during ward rounds. Their lack of subjective experience renders respect for their feelings unnecessary or even inappropriate. And since such objects are devoid of the capacity to act in either an informed or uninformed way, the requirement that doctors supply their patients with information about their conditions and treatment options is inapplicable.

Again I have argued that the discursive constructions, originating in the broader medical culture and brought to life in the context of this particular unit, are not deterministic. This point is illustrated both by those doctors who deviate from them in their talk and other actions, and by the patients themselves, some of whom actively resist their ascribed status, for example, demanding recognition, asking for information and making their own decisions. However, I have also argued in this chapter, in agreement with much of the previous work in this field, that the path of patients' resistance is neither easy nor necessarily likely to promote their best interests, frequently being met instead with more vehemently suppressive measures.

I have attempted to show in this chapter that these discursive constructions, identified by previous research as prominent in the broader medical culture and animated within the Greenland's emergency unit's local context, have significant implications for the quality of healthcare delivered. In particular, I have shown that distinct groups of doctors and patients are brought into being and maintained through conversational means, talk between groups in the unit being highly restricted and 'border crossing' in either direction being negatively sanctioned. Thus, conversations about patients, ranging from the simple conveyance of information from one doctor to another to discussions of weighty decisions about treatment and management options tend to exclude the patient whom they concern, and decisions are taken solely by the doctors, without reference to their patients' unsolicited views.

Construed as unlike each other in every way, there is, in addition, little possibility for the perception of similar or shared experience between doctors and patients. Empathy is therefore unlikely. Doctors are thus not only able to perform potentially distressing procedures without the complication of empathising with their patients at these crucial moments. They are also able to disregard their patients' feelings even when such distantiation is not required for the successful completion of their tasks. Doctors can thus subject their patients, for example, to insensitive treatment and humiliation without concern for the effects of their actions on their patients' overall well-being. In addition, the existence of two distinct and coherent groups facilitates ascription of collective rather

than individual responsibility amongst doctors. This collective responsibility protects them from personal accountability for their less desirable actions and enables individual doctors to defer responsibility for adverse events to the group. The possibility for such deference further facilitates the delivery of inhumane care by diminishing the likelihood that the doctor concerned will be held personally accountable or have to face the consequences of her actions.

Again, a counter discourse exists in terms of which doctors are able to acknowledge their patients' subjectivities, generating the possibility for empathy and for practices that, for example, incorporate patients in decision-making about treatment options. These alternative constructions both demonstrate the possibility for individual doctors working within local contexts to diverge from the dominant discursive practices prominent in the broader medical culture and for the generation of contextually sensitive, and hence more realistically achievable, treatment plans. These alternatives thus highlight the dynamic nature of discourse and the possibility for change.

In the third empirical chapter I have attempted to reveal an apparent contradiction, in terms of which the positions occupied by doctors and patients in broader medical culture, as animated in the local emergency room context, undergo a superficial shift that paradoxically denies and enables maintenance of the doctors' power. As sole agents within the narrative landscape, doctors are construed by their own definition as necessarily responsible for everything that occurs in the unit, including adverse events. In view of the inherent limitations of medical practice, the poor social conditions and resource shortages that characterise this particular hospital and the community that it serves, and the ultimate inevitability of death, this construction of doctors as responsible is necessarily accompanied by the potential for self-doubt, recrimination and guilt when their efforts fail. Attempting to navigate the structures that produce this uncomfortable position in which they find themselves, I have shown in this chapter how doctors sometimes defensively project blame outwards, onto their patients and others, for all manner of untoward happenings, including their patients' illnesses and death and indeed the doctors' own actions. Patients are thus transformed in their doctors' constructions

from objects devoid of the capacity for action into the culpable causes of every problem, dangerous to themselves and to those around them. And in turn, doctors become, far from the powerful superheroes as whom they were originally cast, their patients' hapless victims. The relationship between them is thereby changed from one in which the doctors' role is to help their patients into one in which they must defend themselves against them. In combination with the doctors' discursive loss of power and consequent need to reassert it, these constructions create an incentive for doctors to engage in avoidant behaviours and to adopt defensive strategies, which, in these terms, seem justifiable and indeed warranted. In addition, the sense of victimisation that doctors experience in terms of these constructions produces anger toward those seen to be persecuting them or making unmanageable demands, spawning the opportunity for doctors to commit aggressive and abusive acts. Again, patients must take the blame for these actions if their doctors are to retain their positive self-evaluations. A vicious cycle is thus established, in terms of which the provision of humane care becomes ever less likely.

Thus, I have attempted to show in the analysis presented in this thesis that the hopelessly unrealistic expectations defined for doctors within the narratives of science and of masculinity lead, in many instances, to inevitable failure. In the absence of discursive resources for coping with these failures in ways that enable continued positive self-evaluations, doctors are subject to perpetual feelings of guilt, to which they respond by projecting blame onto their patients, creating an antagonistic relationship between them. The doctors are thus set up, both by their own narrative constructions and by the realities of economics, disease and death with which they are faced, to doubt themselves and their worthiness of the only positive identity on offer within the dominant discourse, namely that of all-powerful agent. Through the processes outlined above, in which doctors and patients respond to the available discourse and the material realities with which they are confronted, the delivery of inhumane care is rendered a likely outcome.

This study has thus provided anecdotal evidence of the continued prevalence of the abuse of patients by hospital staff in South African public sector hospitals, as found by previous

research and reported in numerous newspaper articles. Weaving together the often disparate or implicit explanations for the delivery of inhumane healthcare offered by a wide variety of other authors covering a broad range of topics, I have used these interrelated threads to highlight the discursive mechanisms whereby such acts are enabled in the specific context of the Greenland's emergency unit. Thus, while past research has identified many of the themes discussed in this thesis and has even linked some of these, individually, with the possibility for abuse and delivery of inhumane care, this thesis has contributed to the field through highlighting and articulating the interaction between the various themes previously described. It has further shown, through illustration of concrete events in a particular setting, how not just one theme but the myriad of related themes, operating together to form coherent narratives, represent 'pathways' to inhumane care, making possible actions that in other discursive contexts might seem unjustifiable or even unthinkable. Foregrounding the influence of the social and meaning-laden context on medical practice, the thesis has shown how the actions of the doctors within this particular unit are framed by broader cultural understandings identified within a diverse range of previous studies, in interaction with the realities of the local setting. I have thus tried to bring into view a network of features of the 'invisible biomedical lens' alluded to in past studies of medical culture, and reproduced and animated within the specific context in which this study was conducted. Through detailed exploration of these features within the Greenland's emergency unit, the study is intended to show how these coherent, interacting narratives and their multiple components are brought to bear on the sense that individual doctors make of their experiences, predisposing them to the delivery of inhumane care but at the same time, as indicated by their occasional deviations from the dominant 'pathways', remaining non-deterministic and therefore amenable to change.

Interestingly, within the South African context, and in light of the findings of previous studies that race and class represent key variables influencing the quality of medical interactions, overtly racialised or class-related discourses did not emerge in this analysis. In the case of race, doctors in the unit were from diverse race groups and there was therefore no clear demarcation between doctors and patients in these terms. This characteristic may thus have been backgrounded by the participants in this study in

favour of other characteristics more useful in constructing the distinction between doctors' and patients' groups. It is perhaps more surprising in these terms that class issues did not emerge as key features of the divide between doctors and patients, as the two groups were more obviously distinct in this sense. However, it is worth noting that some of the stereotypes in terms of which doctors construed their patients, for example as ignorant, stupid and irresponsible, are, within the South African context, also representative of stereotypes sometimes applied to the poor. It may be, therefore, that within the context of the emergency unit class distinctions are in fact a feature contributing to identity construction and to the construction of associated relationships, but that the categories of doctor and patient are so strong in this context that they overshadow these. Nevertheless, they might be discernible through an analytic lens more finely attuned to this issue.

Some concluding remarks

In conclusion, then, this research has shown that there is indeed a vast gap between legislation and ethical principles and practice, at least in the unit in which it was conducted. This research can make direct claims only with respect to this particular context. However, the relationship between the findings of this study and those of both international and other local South African researchers suggests that the context of this study is not unique but that, on the contrary, the patterns identified here are, as d'Oliveira et al. (2002) contend, "commonplace" in the delivery of health care.

While a few moments spent in almost any public sector emergency unit in South Africa will provide overwhelming evidence of the resource shortages, patient overload and associated stress that one might assume would lead to shortcomings in the behaviour of the staff, it seems that internationally relevant 'discursive pathways' exist that facilitate particular forms of behavioural shortcomings, leading to the delivery of inhumane care. Not once, for example, did I observe doctors abusing each other – avoidance, callousness, ridicule and aggression, while unarguably made more likely by exposure to adverse structural conditions, were reserved solely for patients and assumed a form in keeping with that described by studies globally. In addition, while in an ideal world inhumane

practices would never occur in medical settings, in reality it might be expected that under extremely stressful conditions doctors may from time to time commit acts that violate standards for humane care. However, what is striking in the analysis presented in this thesis is the routine and even obviously justifiable status ascribed to these actions when they do occur. While it might be unrealistic to expect of doctors that they never err in the provision of humane healthcare, any aberrations should, if they are to be kept to a minimum, be viewed as such, and not as ordinary, expected and even necessary aspects of health care delivery. The argument in this thesis, then, is that acts of avoidance, callousness, aggression and so on are not merely errors committed by individuals under stress. Rather, they are the product of a more systemic problem, namely a discursive context that renders such actions both easily accessible and justifiable.

This study has thus highlighted, by weaving together relevant themes in the literature on the culture and practice of medicine, the importance of an understanding of these aspects for truly understanding the occurrence of inhumane, abusive or otherwise poor medical practices. The study has illustrated the emergence of these practices in response to a wide range of interrelated contextual features, both universal in medical culture and particular to the local context. Based on these illustrations and on the arguments associated with them, it appears that, while legislation and ethical principles may define rules and standards for individual doctors' actions, the discursive environment within which medicine is practiced is key to determining the extent to which these rules and standards will be adhered to and upheld. In the words of Fisher (1986: p. 4),

“It would be easier...if the problem could be seen as an individual one. Individual doctors could be depicted as particularly insensitive or inept, while specific patients could be described as either too emotional to understand complex medical explanations or too dependent on authority to make independent medical decisions. While (individually-oriented explanations) would be simpler and perhaps even more plausible or more easily demonstrated empirically, they merely blame the individuals, obscure the process through which medical decisions are reached, and isolate the physician-patient relationship from the cultural, structural and institutional context...”

In agreement with Fisher, my argument attempts to avoid an overly simplistic and narrow view of poor medical practice, and one that blames the individual for events in which she is certainly an active participant, but that are also of much broader origin than his individual character, attitudes, responses to stress and so on. Rather, I argue, the ‘invisible lens’ of medical culture needs to be brought into view and carefully scrutinised in order to ascertain its contribution to the delivery of poor, inhumane or abusive care and even, potentially, to the realisation of poor health outcomes. If this is so then insight into the gap between legislation and ethical guidelines and actual practice that brings into view the details of interaction and the consciously intended and unconsciously produced meanings of talk is essential to the possibility of bridging this gap and of bringing medical practice into line with patients’ rights.

Some possibilities for effecting change

Marx’s observation that, “The philosophers have only *interpreted* the world, in various ways; the point, however, is to *change* it,” (as cited in Waitzkin, 1991: p. 179) underscores the importance of ensuring that understandings of the reasons for inhumane care are used to enhance the possibility for transformation. A significant body of work has prescribed a huge variety of techniques for making medical practice more humane. The important point that the findings presented in this thesis make is that, if the conduct of individual doctors is to be changed, the context in which they practice must also change. Thus the multiplicity of instructions to doctors, asking them to listen to their patients empathically and with fewer interruptions, to provide them with fuller explanations and to engage their patients in the process of decision-making, for example, are unlikely to lead to the delivery of humane health care in the current environment.

This environment presents, on the contrary, too many incentives and opportunities for domination and obstacles to equality between doctors and patients, characterising them in binary terms, denying patients’ status as subjects, imparting omnipotent responsibility to their doctors, and making no allowance for unavoidable medical failure or for doctors’ vulnerability to emotion. Rather than asking how individual doctors should better treat

their patients, therefore, the implication of the arguments I present in this thesis is that we would do better to ask how we can change broader medical culture and stimulate the development of local cultures that encourage understandings, identities and practices that promote the protection of patients' rights. As Katz (1984) points out, such a shift will not be easy "for professionals are unaccustomed to looking that deeply into their professional psyche" (p. 150), and will require "nothing less than uprooting the prevailing authoritarian value and belief systems and replacing them with more egalitarian ones."

It is toward such a major and difficult shift that this thesis hopes to offer its contribution through providing a source of social criticism that "exerts its power through its ability to demystify those elements of culture that enable and justify social oppression" (Waitzkin, 1991: p 181). It hopes to reveal previously hidden alternatives for constructing medical practice that hold the potential to transform the relationship between doctors and patients. In addition to the structures of understanding that I have outlined with this intent, through its very existence as a text that positions the doctor, always before the subject of knowledge, as the object of knowledge (Armstrong, 2002), this thesis hopes to contribute to subverting those discourses that render patients susceptible to abuse and doctors to abusive action.

Thus, the issue of inhumane and abusive medical interactions is neither simple nor easily addressed. The inequality between doctors and patients, with the associated potential for doctors' abuse of their power, is embedded in medical and broader cultural thinking. And resistance, for any individual patient, has been shown to be a risky battle, in terms of which the doctor has little to lose, whereas the patient gambles his life. While the literature details the roots and mechanisms of imbalanced power, solutions to this complex and daunting problem that account for its complexity as well as for the risk to the patient and indeed to the existence of the medical profession, on whose expertise few of us would be happy to relinquish our dependence, remain to be found.

Limitations

While this study has produced findings that are, I believe, both interesting and important, they are also subject to certain limitations. First and foremost, the findings presented here

are the product of research conducted in one specific context, namely an emergency unit in a South African public sector hospital. They may well have implications for other contexts, as indicated by their resonance with the international literature. However, the likelihood that the contextual features described globally and in the specific context of this study will lead elsewhere to the same extent and regularity of inhumane practice as described here in the Greenlands emergency unit cannot be assumed and would need to be established through further research. In addition, the methods employed in the production of these findings have exerted their influence on their form. While being a resource in terms of enabling ways of seeing and interpreting the data, they have also closed off other possible interpretations that may have been produced through different means. In particular, my role as collector and interpreter of the material has informed both the production and analysis of data. In all these ways, this study should be treated as the outcome of a particular process in a particular place at a particular time and in some senses bound to those circumstances.

Further research

In order for the findings presented in this study to be better able to contribute toward the transformation of medical practice, further research is required. In particular, it seems very important to establish the extent to which abusive practices are prevalent within the South African health care system more broadly. Despite the limitation emphasized on the previous page, it is unlikely that the frequency of the events described in this thesis is peculiar to the unit in which the research was conducted. This is indicated by newspaper reports, by the small number of other studies documenting abuse in South African hospitals and by the extreme stress under which doctors working in the public sector healthcare system are having to operate. It further seems logical that the medical profession's awareness of abusive practices and the violation of patients' rights is a prerequisite for change. Establishment of the prevalence of abuse therefore seems the more urgent.

While inhumane care is unacceptable in itself, it is also probable that it has consequences that extend beyond the events that occur within the health care setting. Research

exploring the links between inhumane service delivery and treatment outcomes would thus be useful in establishing the extent to which such practices are impacting not only on patients' rights, as described in this thesis, but on the healthcare system itself in the form of wasted resources. Linked by previous research to ineffective communication between doctors and patients, it is no great leap to imagine that abusive treatment also affects diagnostic acumen, adherence to treatment and patients' return for follow up visits. If we accept, for example, as the majority of medical practitioners do, that a patient's history is amongst the most sensitive diagnostic tools, and that, as suggested by the theoretical standpoint from which this study departed, this history represents an artefact jointly produced between doctor and patient, then the absence or presence of humane care must have profound implications for accurate diagnosis. In addition, the active involvement of the patient in managing her own condition is widely accepted as desirable and necessary. It therefore seems worth considering that her acceptance of the doctor's diagnosis and of the prescribed treatment is likely to be strongly influenced by the nature of her relationship with her doctor, as must be her willingness to return for follow up care. It seems disconcertingly plausible, therefore, that abusive practices on the part of doctors are not merely responsive to the stresses that result from working in an overburdened system. In fact it seems likely that they contribute to them, increasing the average number of times that each patient will return to the hospital with the same ineffectively treated condition, as well as increasing the severity of presenting conditions, as patients postpone their visits to the hospital for as long as possible. Establishing such linkages through sound research seems important not only for the contribution this might make to improving the results of medical care. In a world that predominantly recognises only the most tangible events and that is in constant search of measurable outcomes, the establishment of such linkages would also represent a significant contribution toward making a case for the importance of measures to ensure humane medical practice. Lastly, and perhaps most importantly, studies investigating the characteristics of positive interactions between doctors and patients, and the discourses that enable them, would provide further insight into what might be required for successful intervention.

REFERENCES

- Alsop, J. & Mulcahy, L. (1999). Doctors' responses to patient complaints. In M. M. Rosenthal, L. Mulcahy & S. Lloyd-Bostock. (Eds.). *Medical mishaps: pieces of the puzzle* (pp. 124-139). Buckingham, UK.: Open University Press.
- Andersen, H. M. (2004). Villagers: differential treatment in a Ghanaian hospital. *Social Science & Medicine*, 59, 2003-2012.
- Anderson, K., & Jack, D.C. (1991). Learning to listen: Interview techniques and analyses. In S.B. Gluck & D. Patai (Eds.), *Women's words: The feminist practice of oral history* (pp. 11-26). New York: Routledge.
- Annandale, E. & Hunt, K. (1998). Accounts of disagreements with doctors. *Social Science & Medicine*, 46, 119-129.
- Antaki, C. (1994). *Explaining and arguing: the social organisation of accounts*. London, UK.: Sage Publications.
- Apker, J. & Eggly, S. (2004). Communicating professional identity in medical socialization: considering the ideological discourse of morning report. *Qualitative Health Research*, 14, 411-429.
- Armstrong, D. (2002). *A new history of identity: a sociology of medical knowledge*. New York, NY.: Palgrave.
- Arney, W. R. & Bergen B. J. (1984). *Medicine and the management of living: taming the last great beast*. Chicago: University of Chicago Press.
- Atkinson, P. (1981). Time and cool patients. In P. Atkinson & C. Heath (Eds.). *Medical work: realities and routines* (pp. 41-54). Farnborough, England: Gower Publishing Company.
- Atkinson, P. (1984). Training for certainty. *Social Science & Medicine*, 19, 949 - 956.
- Atkinson, P. (1990). *The ethnographic imagination: textual constructions of reality*. London: Routledge.
- Atkinson, P. (1995). *Medical talk and medical work: the liturgy of the clinic*. London, UK.: Sage Publications.

- Atkinson, P. (1999). Medical discourse, evidentiality and the construction of professional identity. In S. Sarangi and C. Roberts (Eds.). *Talk, work and institutional order: discourse in medical, mediation and management settings* (pp. 75-108). Berlin, Germany: Mouton de Gruyter.
- Atkinson, P. (2004). The discursive construction of competence and responsibility in medical collegial talk. *Communication in Medicine, 1*, 13 – 23.
- Atkinson, P. & Hammersley, M. (1994). Ethnography and participant observation. In Denzin, N. & Lincoln, Y. (Eds.). *Strategies of Qualitative Inquiry* (pp.248 – 261). London: Sage.
- Atkinson, P. & Hammersley, M. (2007). *Ethnography: principles in practice, 3rd edition*. [e-book]. Taylor and Francis: Available at <http://www.canterbury.ac.uk/library/e-library/Taylor-and-Francis-ebooks.asp>.
- Atkinson, P. and Pugsley, L. (2005). Making sense of ethnography and medical education. *Medical Education, 39*, 228–234.
- Austin, J. L. (1976). *How to do things with words*. Oxford, U.K.: University Press.
- Back, A., Meier, D. & Morrison, R. (2001). The inner life of physicians and care of the seriously ill. *The Journal of the American Medical Association, 286*, 3007-3014.
- Baldwin-Ragaven, L., de Gruchy, J. & London, L. (1999). *An ambulance of the wrong colour: health professionals, human rights and ethics in South Africa*. Rondebosch, CT.: University of Cape Town Press.
- Barber, C. F. (2007). Abuse by care professionals. Part 1: an introduction. *British Journal of Nursing, 16*, 938-940.
- Barry, C. A., Bradley, C. P., Britten, N., Stevenson, F. A. & Barber, N. (2000). Patients' unvoiced agendas in general practice consultations: qualitative study. *British Medical Journal, 320*, 1246-1250.
- Billig, M. (1999). *Freudian repression: conversation creating the unconscious*. Cambridge: Cambridge University Press.
- Borges, S. (1986). A feminist critique of scientific ideology: an analysis of two doctor-patient encounters. In S. Fisher & A. D. Todd (Eds.). *Discourse and institutional authority: medicine, education, and law* (pp. 26-48). New Jersey, USA.: Ablex Publishing Corporation.

- Boyd, E. & Heritage J. (2006). Taking the history: questioning during comprehensive history-taking. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 151-184). Cambridge, UK.: Cambridge University Press.
- Brennan, T. A., Leape, L. L., Laird, N. M., Hebert, L., Localio, A. R., Lawthers, A. G., Newhouse, J. P., Weiler, P. C., & Hiatt, H. H. (1991). Incidence of adverse events and negligence in hospitalized patients: results of the Harvard medical practice study I. *The New England Journal of Medicine*, 324, 370-376.
- Buller, A. J., Connell, B., & Spencer, A. F. (2005). Compliance: clear communication's critical. *British Journal of Ophthalmology*, 89, 1370-1370.
- Burkitt, I. (1998). The death and rebirth of the author: the Bakhtin circle and Bourdieu on individuality, language and revolution. In M. M. Bell and M. Gardiner (Eds.). *Bakhtin and the social sciences* (pp. 163-180). London, U.K.: Sage Publications.
- Cassell, E. J. (1982). The nature of suffering and the goals of medicine. *The New England Journal of Medicine*, 306, 639-645.
- Cassell, J. (1992). On control, certitude, and the "paranoia" of surgeons. In J.M. Morse (Ed.). *Qualitative Health Research* (pp. 170-191). Newbury Park, CA.: Sage Publications.
- Charles, C., Gafnia, A. & Whelan, T. (1999). Decision-making in the physician–patient encounter: revisiting the shared treatment decision-making model. *Social Science & Medicine*, 49, 651-661.
- Chomsky, N. (1979). *Language and responsibility*. Sussex: The Harvester Press.
- Cicourel, A. (1987). The interpenetration of communicative contexts: examples from medical encounters. *Social Psychology Quarterly*, 50, 217-226.
- Cicourel, A. (1999). The interaction of cognitive and cultural models in health care delivery. In S. Sarangi and C. Roberts (Eds.). *Talk, work and institutional order: discourse in medical, mediation and management settings* (pp. 183-226). Berlin, Germany: Mouton de Gruyter.
- Clarence, J. & Sundram, J.D. (1993). Obstacles to reducing patient abuse in public institutions. *Culture, Medicine and Psychiatry*, 17, 235-253.
- Clark, J.A. Mishler, E. (1992). Attending to patients' stories: reframing the clinical task. *Sociology of Health and Illness*, 14, 344 – 372.

- Cohn, N. (1994) Attending to emotional issues on a special baby care unit. In A. Obholzer and V. Z. Roberts (Eds.). *The unconscious at work: individual and organisational stress in the human services* (pp. 60-74). London, UK: Routledge.
- Conrad, P. (1988). Learning to doctor: reflections on recent accounts of the medical school years. *Journal of Health and Social Behavior*, 29, 323-332.
- Coombs, R. & Goldman, L. (1973). Maintenance and discontinuity of coping mechanisms in an intensive care unit. *Social Problems*, 20, 342-355.
- Cooper, B. (2002). Boys don't cry and female masculinity: reclaiming a life and dismantling the politics of normative heterosexuality. *Critical Studies in Media Communication*, 19, 44 – 63.
- Costello, J. (2002). Do not resuscitate orders and older patients: findings from an ethnographic study of hospital wards for older people. *Journal of Advanced Nursing*, 39, 491-499.
- DA: Boy's death 'inexcusable' (2009, May 28). Mail & Guardian. Retrieved from <http://www.mg.co.za>.
- Dartington, A. (1994). Where angels fear to tread: idealism, despondency and inhibition of thought in hospital nursing. In A. Obholzer and V. Z. Roberts (Eds.). *The unconscious at work: Individual and organisational stress in the human services* (pp. 101-109). London, UK: Routledge.
- DelVecchio-Good, M. (1985). Discourses on physician competence. In R. A. Hahn and A. D. Gaines (Eds.). *Physicians of western medicine: anthropological approaches to theory and practice* (pp. 247-267). Dordrecht, Holland: D. Reidel Publishing Company.
- DelVecchio-Good, M. (1995). Cultural studies of biomedicine: an agenda for research. *Social Science & Medicine*, 41, 461-473.
- DelVecchio-Good, M. & Good, B. J. (2000). Clinical narratives and the study of contemporary doctor-patient relationships. In G. Albrecht, R. Fitzpatrick, & S. Scrimshaw (Eds.). *Handbook of social studies in health and medicine* (pp. 243-258). London, England: Sage Publications.

- De Peuter, J. (1998). The dialogics of narrative identity. In M. M. Bell and M. Gardiner (Eds.). *Bakhtin and the social sciences* (pp. 30 - 48). London, U.K.: Sage Publications.
- D'Oliveira, A. F., Diniz, S. G. & Schraiber, L. B. (2002). Violence against women in health-care institutions: an emerging problem. *Lancet*, 359, 1681-1685.
- Donnelly, W. J. (1997). Medical writings: the language of medical case histories. *Annals of Internal Medicine*, 127, 1045-1048.
- Dreyer, J. & Geist, P. (1993). The demise of dialogue: a critique of medical encounter ideology. *Western Journal of Communication*, 57, 233-246.
- Drife, J. O. (1998). Narrative in surgery. In T. Greenhalgh & B. Hurwitz (Eds.). *Narrative based medicine: dialogue and discourse in clinical practice* (pp. 110-117). London, U.K.: BMJ Books.
- Eisenhart, M. (2001). Changing conceptions of culture and ethnographic methodology: recent thematic shifts and their implications for research on teaching. In Richardson, V. (Ed.). *Handbook of Research on Teaching, 4th Edition* (pp. 209-225). Washington, DC: American Educational Research Association.
- Engeström, Y., Brown, K., Engeström, R., & Koistinen, K. (1990). Organizational forgetting: an activity-theoretical perspective. In D. Middleton & D. Edwards (Eds.). *Collective remembering* (pp. 139-168). London, UK.: Sage Publications.
- Erickson, F. (1999) Appropriation of voice and presentation of self as a fellow physician: aspects of a discourse of apprenticeship in medicine. In S. Sarangi and C. Roberts (Eds.). *Talk, work and institutional order: discourse in medical, mediation and management settings* (pp. 109-144). Berlin, Germany: Mouton de Gruyter.
- Eriksson, C. & Saveman, B. (2002). Nurses' experiences of abusive / non-abusive caring for demented patients in acute care settings. *Scandinavian Journal of Caring Sciences*, 16, 79-85.
- Fainzang, S. (2002). Lying, secrecy and power within the doctor-patient relationship. *Anthropology & Medicine*, 9, 117 – 133.
- Fairclough, N. (2001). *Language and Power* (2nd ed.). London, U.K.: Longman.

- Fassin, D. (2008). The elementary forms of care: an empirical approach to ethics in a South African hospital. *Social Science & Medicine*, 67, 262-270.
- Finkler, K. (1991). *Physicians at work, patients in pain: biomedical practice and patient response in Mexico*. Oxford, UK: Westview Press.
- Finkler, K. (2004). Biomedicine globalized and localized: Western medical practices in an outpatient clinic of a Mexican hospital. *Social Science & Medicine*, 59, 2037-2051.
- Finkler, K. (2008). Can bioethics be global and local, or must it be both? *Journal of Contemporary Ethnography*, 37, 155-179.
- Finkler, K., Hunter, C., & Iedema, R. (2008). What is going on? Ethnography in hospital spaces. *Journal of Contemporary Ethnography*, 37, 246-250.
- Fisher, S. (1980). *The context of medical decision-making: an analysis of practitioner/patient communication* (SEDL Report 75). Retrieved from the Education Resources Information Centre website:
http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/38/95/a2.pdf.
- Fisher, S. (1984). Doctor-patient communication: a social and micro-political performance. *Sociology of Health and Illness*, 6, 1-29.
- Fisher, S. (1986). *In the patient's best interest: women and the politics of medical decisions*. New Brunswick, NJ: Rutgers University Press.
- Fisher, S. (1991). A discourse of the social: medical talk/ power talk/ oppositional talk. *Discourse & Society*, 2, 157-182.
- Fisher, S. (1995). *Nursing wounds: nurse practitioners, doctors, women patients and the negotiation of meaning*. New Brunswick, NJ.: Rutgers University Press.
- Fisher, S. & Groce, S. (1985). Doctor-patient negotiation of cultural assumptions. *Sociology of Health and Illness*, 7, 342-374.
- Fisher, S. & Groce, S. (1990). Accounting practices in medical interviews. *Language in Society*, 19, 225-250.
- Fordred, L. (2002). Narrative in Anthropology 500: course outline. Unpublished teaching material. Department of Social Anthropology: University of Cape Town.

- Foster, D., Haupt, P. and de Beer, M. (2005). *The theatre of violence: narratives of protagonists in the South African conflict*. South Africa: HSRC Press.
- Fox, R. (1957). Training for uncertainty. In R. K. Merton, G. C. Reader and P. Kendall (Eds.). *The student physician: introductory studies in the sociology of medical education* (pp. 221 – 227). MA: Harvard University Press.
- Fox, R. (1989). *The sociology of medicine*. Englewood Cliffs, NJ.: Prentice-Hall.
- Francis, D. & Hester, S. (2004). *An invitation to ethnomethodology: language, society and interaction*. London, UK: Sage Publications.
- Francis, N., Rollnick, S., McCambridge, J., Butler, C., Lane, C. & Hood, K. (2005). When smokers are resistant to change: experimental analysis of the effect of patient resistance on practitioner behaviour. *Addiction*, 100, 1175-1182.
- Freidson, E. (1970a). *Professional dominance: the social structure of medical care*. New York, NY.: Atherton Press.
- Freidson, E. (1970b). *Profession of medicine: a study of the sociology of applied knowledge*. New York, NY.: Harper & Row Publishers.
- Freidson, E. (1975). *Doctoring together: a study of professional social control*. Amsterdam, Netherlands: Elsevier Scientific Publishing Company.
- Frosh, S. (2002). *After words: the personal in gender, culture and psychotherapy*. Basingstoke, Hampshire: Palgrave.
- Gardiner, M. (1998). 'The incomparable monster of solipsism': Bakhtin and Merleau-Ponty. In M. M. Bell and M. Gardiner (Eds.), *Bakhtin and the social sciences* (pp. 128-144). London, U.K.: Sage Publications.
- Gergen, M. (1988) Narrative structures in social explanation. In Antaki, C. (Ed.) *Analysing lay explanation: A casebook of methods* (pp. 94-112). Beverly Hills, CA: Sage.
- Gergen, M. (2001) *Feminist reconstructions in psychology: narrative, gender, and performance*. Thousand Oaks: Sage Publications.
- Gibson, D. (2004). The gaps in the gaze in South African hospitals. *Social Science & Medicine*, 59, 2013-2024.
- Gill, V. T. (1998). Doing attributions in medical interaction: patients' explanations for illness and doctors' responses. *Social Psychology Quarterly*, 61, 342 – 360.

- Gill, V. T., Halkowski, T. & Roberts, F. (2001). Accomplishing a request without making one: a single case analysis of a primary care visit. *Text, 21*, 55-81.
- Gill, V. T. & Maynard, D. W. (2006). Explaining illness: patients' proposals and physicians' responses. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 115-150). Cambridge, UK.: Cambridge University Press.
- Gobo, G. (2008). *Doing Ethnography*. London: Sage.
- Goffman, E. (1961). *Asylums: essays on the social situation of mental patients and other inmates*. Middlesex, England: Penguin Books.
- Good, B. J. (1994). *Medicine, rationality, and experience: an anthropological perspective*. Cambridge, U.K.: Cambridge University Press.
- Good, B. J. & DelVecchio-Good, M. (1993). "Learning medicine": the construction of medical knowledge at Harvard Medical School. In S. Lindenbaum & M. Lock (Eds.). *Knowledge, power, and practice: the anthropology of medicine in everyday life* (pp. 81-104). Los Angeles, CA.: University of California Press.
- Good, B. J. & DelVecchio-Good, M. (2000). "Fiction" and "historicity" in doctors' stories: social and narrative dimensions of learning medicine. In C. Mattingly & L. C. Garro (Eds.). *Narrative and cultural construction of illness and healing*, (pp. 50-69). Los Angeles, CA.: University of California Press.
- Hafferty, F. W. (1991). *Into the valley: death and the socialisation of medical students*. New Haven, Connecticut: Yale University Press.
- Hahn, R. A. (1985). A world of internal medicine: portrait of an internist. In R. A. Hahn & A. D. Gaines (Eds.). *Physicians of western medicine: anthropological approaches to theory and practice*. (pp. 51-111). Dordrecht, Holland: D. Reidel Publishing Company.
- Hak, T. (1999). "Text" and "context": talk bias in studies of health care work. In S. Sarangi and C. Roberts (Eds.). *Talk, work and institutional order: discourse in medical, mediation and management settings* (pp. 427-452). Berlin, Germany: Mouton de Gruyter.
- Halberstam, J. (1998). *Female Masculinity*. USA: Duke University Press.
- Halford, S. & Leonard, P. (2006). Place, space and time: contextualizing workplace subjectivities. *Organization Studies, 27*, 657-676.

- Harre, R. (1978). Accounts, actions and meanings: the practice of participatory psychology. In M. Brenner, P. Marsh & M. Brenner (Eds.). *The social context of method* (pp. 44-66). London: Billing and Sons.
- Heath, C. (1992). The delivery and reception of diagnosis in the general-practice consultation. In P. Drew & J. Heritage (Eds.). *Talk at work: interaction in institutional settings* (pp. 235-265). Cambridge, UK.: Cambridge University Press.
- Heath, C. (2006). Body work: the collaborative production of the clinical object. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 185-209). Cambridge, UK.: Cambridge University Press.
- Helman, C. G. (2001). *Culture, health and illness* (4th Ed.). London, UK: Arnold.
- Heritage, J & Maynard, D. W. (2006). Introduction: analyzing interaction between doctors and patients in primary health care. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 1-21). Cambridge, UK.: Cambridge University Press.
- Heritage, J. & Robinson, J. D. (2006). Accounting for the visit: giving reasons for seeking medical care. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 48-85). Cambridge, UK.: Cambridge University Press.
- Hilfiker, D. (1997). Facing our mistakes. In G. E. Henderson, N. M. P. King, R. P. Strauss, S. E. Estroff, & L. R. Churchill (Eds.). *The social medicine reader* (pp. 287-292). London, UK.: Duke University Press.
- Hogarth, S. & Marks, L. (1998). The golden narrative in British medicine. In T. Greenhalgh & B. Hurwitz (Eds.). *Narrative based medicine: dialogue and discourse in clinical practice* (pp. 140-148). London, U.K.: BMJ Books.
- Hollway, W. & Jefferson, T. (2000a). *Doing qualitative research differently: free association, narrative and the interview method*. London: Sage Publications.
- Hollway, W. & Jefferson, T. (2000b). Narrative, discourse and the unconscious: the case of Tommy. In Andrews, M., Sclater, S., Squire, C. and Treacher, A. (Eds.). *Lines of narrative: psychosocial perspectives*. London: Routledge.
- Holman, C., Meyer, J. & Davenhill, R. (2006). Psychoanalytically informed research in a NHS continuing care unit for older people: exploring and developing staff's work with complex loss and grief. *Journal of Social Work Practice*, 20, 315-328.

- Iedema, R. (2005). Critical incident reporting and the discursive reconfiguration of feeling and positioning. *Journal of Applied Linguistics*, 2, 325-349.
- Iedema, R. (2007). Critical incident reporting and the discursive reconfiguration of feeling and positioning. *Journal of Applied Linguistics*, 2, 325 – 349.
- Iedema, R., Flabouris A., Grant S., & Jorm C. (2006). Narrativizing errors of care: critical incident reporting in clinical practice. *Social Science & Medicine*, 62, 134-44.
- Inhorn, M. (2004). Privacy, privatization and the politics of patronage: ethnographic challenges to penetrating the secret world of Middle-Eastern, hospital-based in-vitro fertilization. *Social Science and Medicine*, 59, 2095 – 2108.
- Jackson, M. (2002). *The politics of storytelling*. Copenhagen: university of Copenhagen.
- Jefferson, G. (1984). Transcript notation. In J. Heritage and J. M. Atkinson (Eds.). *Structures of social interaction*. (pp. ix – xvi). New York: Cambridge University Press.
- Jeffery, R. (1979). Normal rubbish: deviant patients in casualty departments. *Sociology of Health & Illness*, 1, 90 – 107.
- Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine*, 47, 1781-1795.
- Katz, J. (1984). *The silent world of doctor and patient*. Baltimore, MD.: The Johns Hopkins University Press.
- Katz, P. (1985). How surgeons make decisions. In R. A. Hahn & A. D. Gaines (Eds.). *Physicians of western medicine: Anthropological approaches to theory and practice*. (pp. 155-175). Dordrecht, Holland: D. Reidel Publishing Company.
- Kelleher, D., Gabe, J., & Williams, G. (1994). Understanding medical dominance in the modern world. In J. Gabe, D. Kelleher, & G. Williams (Eds.). *Challenging medicine* (pp. xi). New York, NY.: Routledge.
- Kelly, D., Pearce, S. & Mulhall, A. (2004). ‘Being in the same boat’: ethnographic insights into an adolescent cancer unit. *International Journal of Nursing Studies*, 41, 847–857.

- Kirkmayer, L. J. (2000). Broken narratives: clinical encounters and the poetics of illness experience. In C. Mattingly & L. C. Garro (Eds.). *Narrative and the cultural construction of illness and healing* (pp. 153-180). Los Angeles, CA.: University of California Press.
- Konner, M. (1997). Basic clinical skills: The first encounter. In G. E. Henderson, N. M. P. King, R. P. Strauss, S. E. Estroff, & L. R. Churchill (Eds.). *The social medicine reader* (pp. 211-213). London, UK.: Duke University Press.
- Lakoff, G. (1987). *Women, fire and dangerous things: what categories reveal about the mind*. Chicago: Chicago University Press.
- Lakoff, G. & Johnson, M. (1980). *Metaphors we live by*. Chicago: University of Chicago Press.
- Lazare, A. (1987). Shame and humiliation in the medical encounter. *Archives of Internal Medicine*, 147, 1653–1658.
- Levin, M. (2005a). The importance of language and culture in paediatric asthma care: communication problems between doctors and Xhosa speaking parents of children at a paediatric teaching hospital. *Current Allergy & Clinical Immunology*, 18, 8-12.
- Levin, M. (2005b). *Discordant definitions of medical terminology and their impact on communication between English-speaking doctors and Xhosa-speaking patients at a paediatric hospital*. Unpublished PhD thesis: University of Cape Town, Cape Town.
- Lewinsohn, R. (1998). Medical theories, science, and the practice of medicine. *Social Science & Medicine*, 46, 1261-1270.
- Lorber, J. (1975). Good patients and problem patients: conformity and deviance in a general hospital. *Journal of Health and Social Behavior*, 16, 213-225.
- Lucas, M. & Stevenson, D. (2006). Violence and abuse in psychiatric in-patient institutions: a South African perspective. *International Journal of Law and Psychiatry*, 29, 195-203.
- Lucas, M. & Stevenson, D. (2005). Institutional victimisation in post-apartheid South Africa. *South African Journal of Psychiatry*, 11, 90-94.

- Luftey, K. (2005). On practices of 'good doctoring': reconsidering the relationship between provider roles and patient adherence. *Sociology of Health & Illness*, 27, 421-447.
- Lund, C. & Flisher, A. (2006). Norms for mental health services in South Africa. *Social Psychiatry and Psychiatric Epidemiology*, 41, 587-594.
- Lupton, D. (2003). *Medicine as culture: illness, disease and the body in western societies*. London, UK.: Sage Publications.
- Malterud, M. & Thesen, J. (2008). When the helper humiliates the patient: a qualitative study about unintended intimidations. *Scandinavian Journal of Public Health*, 36, 92-98.
- Manias, E. and Street, A. (2001). Rethinking ethnography: reconstructing nursing relationships. *Journal of Advanced Nursing*, 33, 234 – 242.
- Maposa, S. (2009, December 7). 'My girl saw her dad die in clinic'. *Cape Argus*. Retrieved from <http://www.iol.co.za>.
- Martin, P. G. & Dreyer, J. (2001). Accounting for care: different versions of different stories in the health care context. In S. L. Herndon & G. L. Kreps (Eds.). *Qualitative research: applications in organizational life* (pp. 121-149). Cresskill, NJ.: Hampton Press.
- Mathai, M. (1997). *A study of the knowledge and problem solving ability of family planning nurses in Mdantsane*. (Masters thesis, University of Cape Town, Cape Town, South Africa).
- Maynard, D. W. (2003). *Bad news, good news: conversational order in everyday talk and clinical settings*. Chicago, USA: The University of Chicago Press.
- Millman, M. (1977). *The unkindest cut: life in the backrooms of medicine*. New York, NY.: William Morrow and Company Inc.
- Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ.: Ablex Publishing Corporation.
- Mishler, E. G. (2004). The unjust world problem: towards an ethics of advocacy for healthcare providers and researchers. *Communication & Medicine*, 1, 97–104.
- Mishler, E. G. (2005). Patient stories, narratives of resistance and the ethics of humane care: a la recherche du temps perdu. *Health*, 9, 431-51.

- Mishler, E. G., Amarasingham, L. R., Hauser, S. T., Osherson, S. D., Waxler, N. E., & Liem, R. (1981). *Social contexts of health, illness, and patient care*. Cambridge, UK.: Cambridge University Press.
- Mizrahi, T. (1984). Managing medical mistakes: ideology, insularity and accountability among internists-in-training. *Social Science & Medicine*, 19, 135-146.
- Mizrahi, T. (1986). *Getting rid of patients: contradictions in the socialization of physicians*. New Brunswick, NJ.: Rutgers University Press.
- Moreira, T. (2004a). Coordination and embodiment in the operating room. *Body & Society*, 10, 109-129.
- Moreira, T. (2004b). Self, agency and the surgical collective: detachment. *Sociology of Health & Illness*, 26, 32 – 49.
- Moreira, T. (2004c). Surgical monads: a social topology of the operating room. *Environment and Planning D: Society and Space*, 22, 53 – 69.
- Morrow, R. A. (1998). Bakhtin and Mannheim: an introductory dialogue. In M. M. Bell and M. Gardiner (Eds.). *Bakhtin and the social sciences* (pp. 145 - 162). London, U.K.: Sage Publications.
- Muller, L. (1999). *The geography of the clinic: spatial form, meaning and practice at a Western Cape community health centre*. (Masters thesis, University of Cape Town, Cape Town, South Africa).
- Mumford, E. (1970). *Interns: from students to physicians*. Cambridge, Mass.: Harvard University Press.
- Murcott, A. (1981). On the typification of 'bad patients'. In Atkinson, P. & Heath, C. (Eds.). *Medical work: Realities and routines*. (pp. 128-140). Farnborough, UK: Gower Publishing Company.
- Ndlovu, N. (2008, August 19). Hospital hell. *Mail & Guardian*. Retrieved from <http://www.mg.co.za>.
- Nofsinger, R. E. (1991). *Everyday conversation: interpersonal communication texts*. London, U.K.: Sage Publications.

- Obholzer, A. (1994). Managing social anxieties in public sector organizations. In A. Obholzer and V. Z. Roberts, (Eds.). *The unconscious at work: individual and organisational stress in the human services* (pp. 169-178). London, UK: Routledge.
- Ochs, E. (2004). Narrative Lessons. In Duranti, A. (Ed.). *A companion to linguistic anthropology*. Oxford: Blackwell Publishing.
- Ochs, E. & Capps, L. (1996). Narrating the self. *Annual Review of Anthropology*, 25, 19-43.
- Oxford English Dictionary (Compact edition.). (1971). New York: Oxford University Press.
- Paechter, C. (2006). Masculine femininities/feminine masculinities: power, identities and gender. *Gender and Education*, 18, 253 – 263.
- Paget, M. A. (1988). *The unity of mistakes: a phenomenological interpretation of medical work*. Philadelphia, USA.: Temple University Press.
- Parker, I. (2005). *Qualitative psychology: introducing radical research*. Maidenhead, U.K.: Open University Press.
- Peräkylä, A. (2002). Agency and authority: extended responses to diagnostic statements in primary care encounters. *Research on Language & Social Interaction*, 35, 219-247.
- Peräkylä, A. (2006). Communicating and responding to diagnosis. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 214-247). Cambridge, UK.: Cambridge University Press.
- Phillips, D. (1996). Medical professional dominance and client dissatisfaction: a study of doctor-patient interaction and reported dissatisfaction with medical care among female patients at four hospitals in Trinidad and Tobago. *Social Science & Medicine*, 42, 1419-1425.
- Pollock, D. (2000). Physician autobiography: narrative and the social history of medicine. In C. Mattingly and L. Garro (Eds.). *Narrative and the cultural construction of illness and healing* (pp. 108-127). Berkeley, CA: University of California Press.
- Pope, C. (2005). Conducting ethnography in medical settings. *Medical Education*, 39, 1180 – 1187.

- Potter, S. J., & McKinlay, J. B. (2005). From relationship to encounter: an examination of longitudinal and lateral dimensions in the doctor–patient relationship. *Social Science & Medicine*, 61, 465-479.
- Rapport, F. & Overing, J. (2007). *Social and cultural anthropology: the key concepts*. New York: Routledge.
- Rawoot, I. (2009, June 20). Not what the doctor ordered. *Mail & Guardian*. Retrieved from <http://www.mg.co.za>.
- Reisigl, M., & Wodak, R. (2001). *Discourse and discrimination: rhetorics of racism and antisemitism*. London, U.K.: Routledge.
- Reissman, C. K. (2005). Exporting ethics: a narrative about narrative research in South India. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 9, 473 – 490.
- Ricoeur, P. (1991) *From text to action: essays in hermeneutics II*. Evanston, IL: Northwestern University Press.
- Rittenberg, W. (1985). Mary: patient as emergent symbol on a paediatrics ward: the objectification of meaning in social process. In R. A. Hahn & A. D. Gaines (Eds.). *Physicians of western medicine: anthropological approaches to theory and practice* (pp. 141-153). Dordrecht, Holland: D. Reidel Publishing Company.
- Robinson, J. D. (2006). Soliciting patients' presenting concerns. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 22-47). Cambridge, UK.: Cambridge University Press.
- Rosenthal, M. M. (1995). *The incompetent doctor: behind closed doors*. Buckingham, UK.: Open University Press.
- Rosenthal, M. M. (1999). How doctors think about medical mishaps. In M. M. Rosenthal, L. Mulcahy, & S. Lloyd-Bostock. (Eds.). *Medical mishaps: Pieces of the puzzle* (pp. 141-153). Buckingham, UK.: Open University Press.
- Rothman, D. J. (2003). *Strangers at the bedside: a history of how law and bioethics transformed medical decision making*. Hawthorne, NY.: Aldine de Gruyter.
- Saks, E. R. (2002). *Refusing care: Forced treatment and the rights of the mentally ill*. Chicago, USA.: The University of Chicago Press.

- Sarangi, S. & Roberts, C. (1999). Introduction: Discursive hybridity in medical work. In S. Sarangi & C. Roberts (Eds.). *Talk, work and institutional order: discourse in medical, mediation and management settings* (pp. 61-74). Berlin, Germany: Mouton de Gruyter.
- Savett, L. A. (2002). *The human side of medicine: learning what it's like to be a patient and what it's like to be a physician*. Westport, CT.: Auburn House.
- Scambler, G. & Britten, N. (2001). System, lifeworld and doctor–patient interaction: issues of trust in a changing world. In G. Scambler (Ed.). *Habermas, critical theory and health* (pp. 45-67). London, England: Routledge.
- Scheeres, H. B., Slade, D. M., Manidis, M., McGregor, J. & Matthiessen, C. (2008). Communicating in hospital emergency departments. *Prospect*, 23, 13-22.
- Schmaling, K. B., Blume, A. W. & Niloofar, A. (2001). Randomized controlled pilot study of motivational interviewing to change attitudes about adherence to medications for asthma. *Journal of Clinical Psychology in Medical Settings*, 8, 167-172.
- Shotter, J. (1993). *Conversational realities: constructing life through language*. London: Sage.
- Shotter, J. & Billig, M. (1998). A Bakhtinian psychology: from out of the heads of individuals and into the dialogues between them. In M. M. Bell and M. Gardiner (Eds.). *Bakhtin and the social sciences* (pp. 13 - 29). London, U.K.: Sage Publications.
- Silverman, D. (1987). *Communication and medical practice: social relations in the clinic*. London, UK: Sage Publications.
- Simpson, P. (1993). *Language, ideology and point of view*. London: Routledge.
- Sinclair, S. (1997). *Making doctors: an institutional apprenticeship*. Oxford, England: Berg Publishers.
- Sixth baby dies from Klebsiella (2007, December 6). *Mail & Guardian*. Retrieved from <http://www.mg.co.za>.

- Slade, D. M., Scheeres, H. B., Manidis, M., Iedema, R. A., Dunston, R., Stein-Parbury, M. J., Matthiessen, C., Herkes, G., and McGregor, J. (2008). Emergency communication: the discursive challenges facing emergency clinicians and patients in emergency departments. *Discourse and Communication*, 2, 271-298.
- Slingsby, B. T. (2004). Decision-making models in Japanese psychiatry: transitions from passive to active patterns. *Social Science & Medicine*, 59, 83-91.
- Smith, D. E. (1998). Bakhtin and the dialogic of sociology: an investigation. In M. M. Bell and M. Gardiner (Eds.), *Bakhtin and the social sciences* (pp. 63-77). London, U.K.: Sage Publications.
- South Africa. (1996). South African Constitution of 1996. Pretoria: Government Printer. [Laws.]
- South Africa. (2003). South African National Health Act No 61 of 2003. Pretoria: Government Printer. [Laws.]
- South Africa. Department of Health. (2000). Patients' Rights Charter. Pretoria: Government Printer.
- Speck, P. (1994). Working with dying people: on being good enough. In A. Obholzer and V. Z. Roberts, (Eds.). *The unconscious at work: individual and organisational stress in the human services* (pp. 94-100). London, UK: Routledge.
- Stadler, J. (1997). *Adolescent perspectives on reproductive health services: results of a three district study in the Northern Province*. 3rd Reproductive Health Priorities Conference, Wilderness, 19 – 22 August 1997.
- Stivers, T. (2006). Treatment decisions: negotiations between doctors and parents in acute care encounters. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 279-312). Cambridge, UK.: Cambridge University Press.
- Stokes, J. (1994). Institutional chaos and personal stress. In A. Obholzer and V. Z. Roberts, (Eds.). *The unconscious at work: individual and organisational stress in the human services* (pp. 19-27). London, UK: Routledge.
- Strong, P. & Davis, A. (1978). Who's who in paediatric encounters: morality, expertise and the generation of identity and action in medical settings. In A. Davis (Ed.). *Relationships between doctors and patients* (pp. 48-75). London, UK: Saxon House.

- Swartz, L. (1989). *Aspects of culture in South African society* (Doctoral thesis, University of Cape Town, Cape Town, South Africa).
- Szasz, T. S. & Hollender, M. H. (1997). The basic models of the doctor-patient-relationship. In G. E. Henderson, N. M. P. King, R. P. Strauss, S. E. Estroff, & L. R. Churchill, (Eds.) *The social medicine reader* (pp. 278-286). London, UK.: Duke University Press.
- Tanassi, L. M. (2004). Compliance as strategy: the importance of personalised relations in obstetric practice. *Social Science & Medicine*, 59, 2053-2069.
- Ten Have, P. (1991). Talk and the institution: a reconsideration of the “asymmetry” of doctor-patient interaction. In D. Boden & D. H. Zimmerman (Eds.). *Talk and social structure: studies in ethnomethodology and conversation analysis* (pp. 138-163). Cambridge, UK: Polity Press.
- Turnbull, E., Flabouris, A. & Iedema, R. (2005). An outside perspective on the lifeworld of an ICU. *Australian Critical Care*, 18, 71-75.
- Turner, B. S. (1995). *Medical power and social knowledge*. London, UK.: Sage Publications.
- Van Amstel, H., & Van der Geest, S. (2004). Doctors and retribution: the hospitalisation of compensation claims in the Highlands of Papua New Guinea. *Social Science & Medicine*, 59, 2087-2094.
- Van der Geest, S. (2005). ‘Sacraments’ in the hospital: exploring the magic and religion of recovery. *Anthropology & Medicine*, 12, 135–150.
- Van der Geest, S. & Finkler, K. (2004). Hospital ethnography: introduction. *Social Science & Medicine*, 59, 1995–2001.
- Van Langenhove, L. & Harre, R. (1999). Introducing positioning theory. In R. Harre & L. Van Langenhove (Eds.). *Positioning theory: moral contexts of intentional action* (pp. 14-31). Oxford: Blackwell Publishers.
- Vavi: Doctors’ salaries awful. (2009, May 29). *Mail & Gaurdian*. Retrieved from <http://www.mg.co.za>.
- Vermeulen, E. (2004). Dealing with doubt: Making decisions in a neonatal ward in The Netherlands. *Social Science & Medicine*, 59, 2071-2085.

- Voloshinov, V.N. / Bakhtin (1994a). Critique of Saussurian linguistics. In P. Morris (Ed.). *The Bakhtin reader: selected writings of Bakhtin, Medvedev, Voloshinov* (pp. 25-37). New York: Edward Arnold.
- Voloshinov, V.N. / Bakhtin (1994b). Critique of Freudianism. In P. Morris (Ed.). *The Bakhtin reader: selected writings of Bakhtin, Medvedev, Voloshinov* (pp. 38-47). New York: Edward Arnold.
- Waitzkin, H. (1991). *The politics of medical encounters: how doctors and patients deal with social problems*. New Haven, CT: Yale University Press.
- Warren, N. & Manderson, L. (2008). Constructing hope: dis/continuity and the narrative construction of recovery in the rehabilitation unit. *Journal of Contemporary Ethnography*, 37, 180-201.
- Weiss, M. (1993). Bedside manners: paradoxes of physician behavior in grand rounds. *Culture, Medicine & Psychiatry*, 17, 235-254.
- West, C. (1984). *Routine complications: troubles with talk between doctors and patients*. Bloomington, USA.: Indiana University Press.
- West, C. (1990). Not just 'doctors' orders': directive-response sequences in patients' visits to women and men physicians. *Discourse and Society*, 1, 85-112.
- West, C. (2006). Coordinating closings in primary care visits: producing continuity of care. In J. Heritage & D. W. Maynard (Eds.). *Communication in medical care* (pp. 379-383). Cambridge, UK.: Cambridge University Press.
- West, C., & Frankel, R. M. (1991). Miscommunication and medicine. In N. Coupland, H. Giles and J. M. Wiemann (Eds.). *"Miscommunication" and Problematic Talk* (pp. 166-194). Newbury Park, Calif.: Sage Publications.
- Wicks, D. (1998). *Nurses and doctors at work: rethinking professional boundaries*. Buckingham, UK.: Open University Press.
- Williams, G. C., McGregor, H. A., King, D., Nelson, C. C. & Glasgow, R. E. (2005). Variation in perceived competence, glycemic control, and patient satisfaction: relationship to autonomy support from physicians. *Patient Education & Counselling*, 57, 39-45.
- Williams, J.R. (2000). Ethics and human rights in South African medicine. *Canadian Medical Association Journal*, 162, 1167-1170.

- Wilson, R. M., Runciman, W. B., Gibberd, R.W., Harrison, B.T., Newby, L. & Hamilton, J.D. (1995). The quality in Australian health care study. *The Medical Journal of Australia*, 163, 458-471.
- Wind, G. (2008). Negotiated interactive observation: doing fieldwork in hospital settings. *Anthropology and Medicine*, 15, 79-89.
- Winefield, H. R., Murrell, T. G., & Clifford, J. (1995). Process and outcomes in general practice consultations: problems in defining high quality care. *Social Science & Medicine*, 41, 969-975.
- Wodak, R (1996). *Disorders of discourse*. London, UK.: Longman.
- Wodak, R. (2006a). Medical discourse: doctor-patient communication. *Encyclopedia of Language & Linguistics*, 7, 681-687.
- Wodak, R. (2006b). Blaming and denying: pragmatics. *Encyclopedia of Language & Linguistics*, 2, 59 – 64.
- Wood, K., Maepa, J. & Jewkes, R. (1997). *Adolescent sex and contraceptive experiences: perspectives of teenagers and clinic nurses in the Northern Province*. MRC technical report, Pretoria.
- Zagier-Roberts, V. (1994). The self assigned impossible task. In A. Obholzer and V. Z. Roberts (Eds.). *The unconscious at work: individual and organisational stress in the human services* (pp. 110-120). London, UK: Routledge.
- Zaman, S. (2004). Poverty and violence, frustration and inventiveness: hospital ward life in Bangladesh. *Social Science & Medicine*, 59, 2025-2036.
- Zaman, S. (2008). Native among the natives: physician anthropologist doing hospital ethnography at home. *Journal of Contemporary Ethnography*, 37, 135 – 154.
- Zaner, R. (2000). Power and hope in the clinical encounter: a meditation on vulnerability. *Medicine, Health Care and Philosophy*, 3, 265-275.